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**A consensus approach towards identifying pertinent  
therapist characteristics in Good Lives Model  
treatment: A research portfolio**

Nick Earley



THE UNIVERSITY  
*of* EDINBURGH

Thesis submission for the degree of  
Doctor of Clinical Psychology

May 2015

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**Date** May 1<sup>st</sup> 2015

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## 1. Thesis abstract

**Background:** The Good Lives Model (GLM) is a novel strengths-based rehabilitation framework, the principles of which are increasingly being integrated into sexual offender treatment programmes. Previous research has suggested that positive therapist characteristics are empirically associated with treatment change in sexual offender treatment. However, considering the theoretically informed shift from a deficits-based approach to a strengths-based approach in GLM-consistent treatment (GLM-CT), it is reasonable to suggest that therapist characteristics might be reflected differently.

**Objective:** To explore and identify, by expert opinion, what therapist characteristics are important in GLM-consistent treatment and how they might be recognised in a treatment session.

**Methods:** A systematic review of the literature was carried out to appraise the reporting quality of studies that used the Delphi method to develop knowledge on psychotherapeutic models. The empirical study used a three-round Delphi method, a structured consensus-gathering technique, with 28 GLM experts from five different countries. The data in the first round were analysed using content analysis, and data in subsequent round were analysed using descriptive statistics.

**Results:** The systematic review found that the reporting quality in Delphi method studies was respectable in relation to the preparatory stages; however, the reporting quality of aspects of the Delphi methodology important for interpreting the results varied. In regards to the empirical paper, experts endorsed 71 items reflecting the GLM ethos and principles in treatment, listed between twelve categories.

**Conclusions:** The results of the present study suggested that therapeutic characteristics previously identified in sexual offending treatment are indeed important in GLM-consistent treatment. However, additional characteristics were highlighted as important by experts, including emphasis on future-focused and strengths-based language, motivational interviewing skills, flexibility with session material and a good knowledge of clients' good lives plans. Finally, the results indicated that use of self-disclosure and directiveness in GLM-CT might need to be elucidated in future research.

## 2. Systematic Review

### Title page

Title: Using and reporting the Delphi method to develop knowledge on psychotherapeutic models: A systematic review

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This journal article has been written in accordance with the author guidelines for *Clinical*

*Psychology Review* (for author guidelines see Appendix A)



## **2.1. Abstract**

The field of psychotherapy is inundated with different treatment models. While guidelines and competency frameworks do exist, more precise details about their operationalisation are often more elusive. The Delphi method is a structured consensus-gathering technique that has been used to consolidate expert knowledge on psychotherapeutic models. This review aimed to appraise the reporting quality of studies that used the Delphi method to develop knowledge on psychotherapeutic models. Following the PRISMA guidelines, a literature search was conducted to identify studies that used the Delphi method to develop knowledge on aspects of psychotherapeutic models, using electronic databases and a manual search of reference lists. A data extraction template was developed based on prior research that assessed four areas of the Delphi method: preparation, participants, methodology and results. The reporting quality was respectable in relation to the preparatory stages; however, the reporting quality of aspects of the Delphi methodology important for interpreting the results varied. In conclusion, if applied rigorously and in a correct manner, the Delphi method could be used more widely to provide clarity on aspects of psychotherapeutic models to help improve current practice.

**Keywords:** Delphi method; Psychotherapeutic models; Reporting quality; Review

## **HIGHLIGHTS**

- **This review reports on the use of the Delphi method to develop knowledge on psychotherapeutic models**
- **The focus was on the Delphi method preparation, participants, methodology and results**
- **Recommendations for future use of the Delphi method in psychotherapy research is discussed**

## **2.2. Introduction**

Since the science of psychology was first formally applied clinically at the end of the 19th century, the practice of psychotherapy has grown exponentially (Benjamin, 2007). Remarkably, a recent estimate now suggests there are over 500 distinct psychotherapies (Pearsall, 2011). The proliferation of available psychotherapeutic options presents a conundrum for contemporary theorists, researchers and clinicians – not only with regard to “what works”, but also concerning how to operationalise models, theories and techniques in practice. Whilst guidelines and competency frameworks exist to guide professionals about what models are empirically supported for different populations and also what therapeutic skills are required (e.g., Roth, Hill, & Pilling, 2009; Fonagy & Roth, 2006), precise details about their operationalisation are often more elusive, especially in relation to specialist and diverse populations. Further elucidation is often necessary with respect to, for instance, the clarification of therapeutic techniques, modifications for use with different populations, or the consolidation of opinions on what represents best practice. Should there be a lack of clarity in the empirical literature with regard to these matters, expert opinion may be required to consolidate knowledge, which could inform practice guidelines or reveal gaps in the literature where further empirical inquiry may be necessary. The Delphi method, a structured technique that uses a series of questionnaires to gain consensus on a topic from a group of experts (Powell, 2003), may be appropriate to address these queries in a systematic and controlled manner.

### **2.2.1 The Delphi Method**

The Delphi method was initially developed by the RAND Corporation to seek the opinion of a panel of experts and to reach consensus on US military operations (Dalkey &

Helmer, 1963). Since then, the method has been extrapolated to a range of different subject areas to explore expert opinion, including information technology (Schmidt, Lyytinen, & Mark Keil, 2001), healthcare (Efsthathiou, Ameen, & Coll, 2008), finance (Kauko, & Palmroos, 2014), education (Osborne, Collins, Ratcliffe, Millar, & Duschl 2003) and psychotherapy (Morrison & Barratt, 2010).

### *2.2.2 Delphi principles*

While the application of the Delphi method varies considerably between studies, four key features are often present: anonymity between participants, iteration, controlled feedback and statistical group response (Heiko, 2012; Lang, 2008; Rowe & Wright, 1999; Skulmoski, Hartman, & Krahn 2007). Firstly, participants remain anonymous to each other throughout the process, which allows them to express their opinion privately, thus reducing the social influence from more dominant group members (Summerville, 2007). Additionally, the iterative enquiry process, over a series of rounds, gives participants the option to change their opinion based on the group response to items, thereby eliminating social pressure from other group members (Rowe & Wright, 1999). However, despite anonymity being a key principle, some researchers have questioned whether it may lead to a lack of accountability resulting in hasty judgements (Sackman, 1975). The iterations of each questionnaire are usually interspersed with controlled feedback. This involves presenting the participants with the responses of other participants and a statistical group response for each item, often the mean or median value (Heiko, 2012; Rowe & Wright, 1999). While some researchers suggest that only studies adhering to these core principles should be classified as Delphi studies (Rowe & Wright, 1999), others argue that the method can be modified depending on the aims and objectives of the study (Adler & Ziglio, 1996; Linstone

& Turoff, 1975). This has resulted in the latter being referred to as a *modified* Delphi and studies adhering to the four core principles, a *classic* Delphi (Skulmoski et al., 2007).

### 2.2.3 *The Delphi preparation*

There are a number of preparatory decisions to make prior to conducting a Delphi method. An important early consideration is the selection of experts to participate on the panel. The literature suggests that with a homogeneous group of experts, a group as small as 10–15 experts can yield results of adequate quality; however, with a more diverse group of experts, the sample size may be considerably larger (Adler & Ziglio, 1996). Another important consideration that is crucial for the validity of the study is the definition of “experts” (De Villiers, De Villiers, & Kent 2005), especially considering that the expert opinions are the foundation on which the output is based. While the definition of experts varies depending on the topic of interest and the research question, in general, it is suggested that experts are selected based on their knowledge and skills of the subject being considered – and their availability and willingness to participate (Adler & Ziglio, 1996). The number of rounds varies depending on the purpose of the research; however, if the aim is to reach consensus and the participants represent a homogeneous sample then fewer than three rounds should be sufficient to reach consensus (Skulmoski et al., 2007).

### 2.2.4 *Delphi process*

It is common for Delphi studies to have two distinct phases: an exploration phase and an evaluation phase (Adler & Ziglio, 1996). The first stage, the “exploration phase”, is often open-ended and gives participants a chance to “brainstorm” ideas (Powell, 2003). The second phase, the “evaluation phase”, involves the use of more structured questionnaire

rounds constructed from the analysis of the first round questionnaire (Skulmoski et al., 2007); here, the participants are presented with statements in the form of a structured questionnaire and asked to rate the importance of each statement on a rating scale (Hultsjö, Berterö, Arvidsson, & Hjelm, 2011). Once the Round 2 questionnaires have been returned, descriptive statistics are calculated based on the group opinion. The results of the second questionnaire then form the basis of the Round 3, and of subsequent questionnaires should consensus not be met (Hasson, Keeney, & McKenna, 2000; Iqbal & Pison-Young, 2009).

The analysis of data varies depending on the structure of rounds and the types of questions asked. If open-ended questions are employed, content analysis techniques are often used to identify categories and themes generated from the data (Iqbal & Pison-Young, 2009; Powell, 2003). It is important that all steps in the analysis of the data are clearly reported, especially considering the reliability of the Delphi method is difficult to ascertain: that is, there is no assurance that the same results would be obtained if the Delphi method was repeated with a different panel of experts. It follows, therefore, that there needs to be transparency with regard to all the steps taken to ensure replicability and repeatability of the results (Armstrong, Gosling, Weinman, & Marteau, 1997; Golafshani, 2003). For the structured questionnaires analysis, measures of dispersion and central tendency are usually used to calculate consensus; however, what statistics are calculated will depend on the consensus criteria set. As there is currently no agreement in the literature on what are the optimum consensus criteria, there are large variations in the consensus criteria used in studies depending on their research aims (Diamond et al., 2014; Heiko, 2012).

Although there are general guidelines for the use of the Delphi method, for instance, in psychology (Iqbal & Pison-Young, 2009) and nursing research (Hasson et al., 2000), no

universal guidelines exist at present, which can result in great variation in how the Delphi method is employed. While its core characteristics (anonymity between participants, iteration, controlled feedback and statistical group response) are often present, the manner in which they are applied varies considerably, making it difficult to distinguish between methodologically weak designs and acceptable modifications to the methodology to answer a particular research question (Powell, 2003). Indeed, recent systematic reviews have reported great disparity in the reporting quality of Delphi studies, both for selecting healthcare indicators (Sinha, Smyth & Williamson, 2011) and to determine outcomes to measure in clinical trials (Boukdedid, Abdoul, Loustau, Sibony, & Alberti, 2011). For instance, Boukdedid et al. (2011) found that of the 80 studies reviewed only 39% of them reported the response rates for each round and only 57% listed the quality indicators selected at the end of the study. Therefore, it is important to review the application of the Delphi method in different research fields to discern areas of good and bad practice in order to improve its future use.

In conclusion, the Delphi method is a powerful consensus technique that has been used to gather expert opinion to consolidate knowledge on aspects of psychotherapeutic models: for instance, the clarification of therapeutic techniques, modifications for use with different populations and the consolidation of opinions on what represent best practice. However, there are large variations in the method, which, if not applied rigorously and appropriately, could undermine the outcomes of individual Delphi studies and the credibility of the technique in psychotherapy. Thus, the aims of the present systematic review were to:

- 1) Systematically review the use and reporting quality of studies that used the Delphi method to develop knowledge on a psychotherapeutic model.

- 2) Discuss potential improvements in the design and reporting of future Delphi studies, based on the findings of this review.

## **2.3. Method**

### *2.3.1. Inclusion and exclusion criteria*

Studies were eligible for inclusion if they reported using the Delphi method to develop knowledge or understanding of a psychotherapeutic model. The inclusion criteria were broad in relation to whether the aim of a study was to increase understanding of the model generally, or if the aim was more specific: for instance, exploring how a model might be modified for use with a new population or to clarify understanding of particular features or techniques within a model. Studies included were those concerned with psychotherapeutic models in any clinical setting. Studies that used the Delphi method to inform mental health guidelines, predict future direction of psychotherapy more broadly, to elicit opinions about general treatment not associated with a core psychotherapeutic model, or were concerned specifically with therapist characteristics, were not considered. Research published in peer reviewed journals and research identified from PhD dissertations were included. Research from poster abstracts, conference presentations and book chapters was excluded due to insufficient information regarding their methodology and results.

### *2.3.2. Search strategy*

The literature search was completed between February and March 2015 to identify suitable studies for inclusion in the review. The Cochrane Database of Abstracts of Reviews of Effects (DARE) was searched to confirm that no similar review had been carried out recently. The following electronic databases were searched: Medline; PsycINFO;

PsycARTICLES; Web of Science and ProQuest Dissertations & Theses Global. The results were confined to articles published in English between 1990 and 2015. Each database was searched using the following search strategy: ((Delphi\* in the domains of: title) AND (model\* OR anxiet\* OR cognitive\* OR therap\* OR depress\* OR psycho\* OR personality\* OR competenc\* OR component\*)). In addition, the reference lists of each study included in the review were searched manually. The results were exported into an Endnote X7.2.1 database and duplications were removed using the duplicate function and a manual search. The initial search yielded 2497 studies (excluding duplicates); of which ten were ultimately considered to have met the review criteria (see Figure 1).

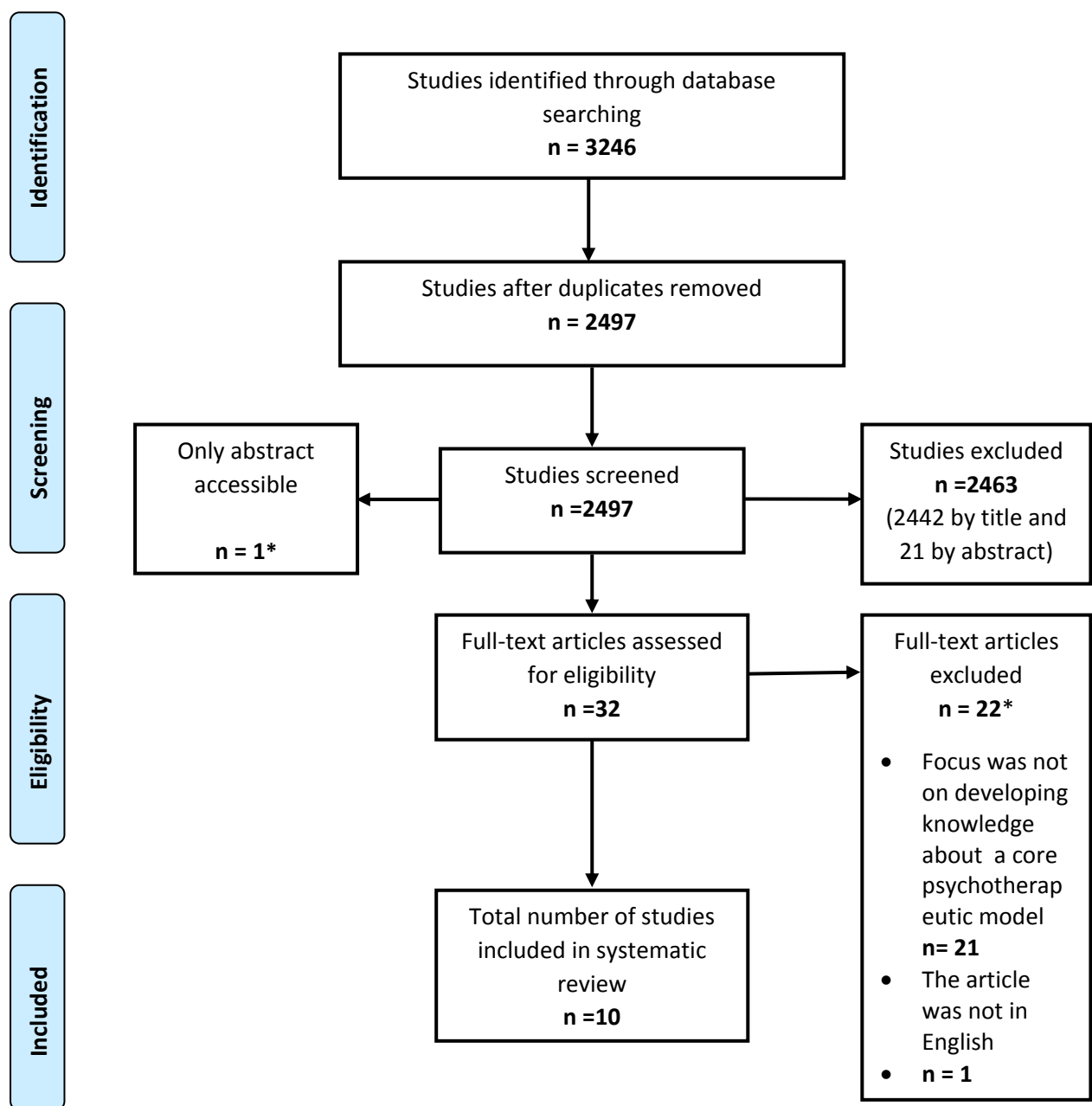
### *2.3.3. Assessing included studies*

To date, there are no standardised quality criteria to assess the quality of Delphi method studies. Therefore, the quality of the studies was measured using a set of criteria developed specifically for the present study. Criteria were based on two prior systematic reviews that examined the reporting quality of the Delphi method for selecting healthcare indicators (Boulkedid et al., 2011) and to determine outcomes to measure in clinical trials (Sinha et al., 2011). In addition, a systematic review that examined the operationalisation of consensus in Delphi studies was considered for the consensus quality criterion (Diamond et al., 2014). The 17 quality criteria are outlined in Table 2. Whereas the previous systematic reviews used a dichotomous rating scale (reported/not reported), it was decided to broaden the scale for the present review to allow for more discrimination between studies: ('Clearly reported': 2 points; 'Partially reported': 1 point; 'Not reported' and 'Not applicable': 0 points). One reviewer tabulated key information from all the articles and a second independently reviewed six of the ten articles, both using an extraction template (Appendix



B). The inter-rater agreement statistic (Kappa) was calculated, yielding a score of .81, reflecting very good agreement (da Costa et al., 2014). Discrepancies were discussed, and, where appropriate, the rating scores were adjusted. The outcomes for each of the quality criteria for each study are detailed in Table 2.

**Figure 1.** Flow chart of the literature review process



\* Full list of excluded articles are available in Appendix C

## **2.4. Results**

A total of 2497 studies were identified (excluding duplicates) through the literature search; of these, 2442 were excluded as they did not meet the criteria for the study. The abstracts of 54 articles were screened, and a further 21 were excluded. A further 32 studies were read in full, of which 22 were rejected for not meeting the review criteria (Appendix C).

### *2.4.1 Study characteristics*

Four of the studies were in the area of family therapy (Blow & Sprenkle, 2001; Edwards, 2001; Jenkins, 1996; White, Edwards, & Russell, 1997), three were in the area of cognitive-behavioural therapy (CBT) (Gould, 2011; Morrison & Barratt, 2009; Roos & Wearden, 2009), one was in the area of psychotherapeutic integration (PI) with older adult clients (Cloosterman, Laan, & Van Alphen, 2013), one was in the area of bereavement therapy (Doughty, 2009) and, finally, one was concerned with problem-solving therapy and psychoeducation (McMurran & Wilmington, 2007). Three studies used a modified Delphi approach, which entailed individual interviews, either to gather information during the rounds (McMurran & Wilmington, 2007), or as a means to further clarify the results (Blow & Sprenkle, 2001; White et al., 1997). Eight studies were published in peer-reviewed journals and two papers (Edwards, 2001; Gould, 2011) were unpublished PhD dissertations.

### *2.4.2 Delphi preparation*

The preliminary steps taken by the studies are detailed in Table 1. The aim and rationale for using the Delphi method were clearly reported and deemed appropriate in all studies. Specifically, four studies used the Delphi method to explore three areas of family therapy: marriage and family therapy (Blow & Sprenkle, 2001; White et al. 1997), a

reflecting team approach (Jenkins, 1996) and multi-family group therapy (Edwards, 2001). Three studies aimed to extend knowledge with regard to cognitive-behavioural therapy. Morrison and Barratt (2009) were interested in identifying the essential elements of CBT for psychosis; Roos and Wearden (2012) aimed to generate a working definition for “socialization to the model” used in CBT; and, finally, Gould (2011) sought to examine how clinicians adapt CBT for clients from a Latino background. Of the final three studies, Doughty (2009) aimed to better elucidate the adaptive grieving styles model (Martin & Doka, 2000) of bereavement in order to augment its application in practice. Cloosterman et al. (2013) aimed to describe psychotherapeutic intergradation (PI) – an integrative psychotherapeutic approach for depression – for use with an older adult population. Finally, McMurran and Wilmington (2007) aimed to improve the effectiveness of psychoeducation and social problem-solving therapy for offenders with a diagnosis of personality disorder.

In relation to the consideration of which items to include in the first round questionnaire and how these were presented to participants, all the studies reported this well. However, in White et al. (1997), although they indicated what questions were asked in the first round, the source of the questions was unclear.

#### *2.4.3 Delphi participants*

The quality of reporting of information relating to participants was generally good. All studies clearly described their criteria and the process they used to identify participants; an expert criterion was detailed in all studies. Four studies used clinical professionals (Blow & Sprenkle, 2001; Cloosterman et al., 2013; Gould, 2011; Roos & Wearden, 2009) and five studies used both clinicians and researchers (Doughty, 2009; Edwards, 2001; Jenkins, 1996; Morrison & Barratt; 2009; White et al., 1997). McMurran and Wilmington (2007) was the

only study to use patients as participants, the rationale for this being clearly reported and congruent with the study aims. Eight studies clearly reported the total sum of participants invited to take part, whereas two studies did not (Cloosterman et al., 2013; McMurran & Wilmington, 2007).

**Table 1.**

Summary of methodological features of Delphi studies

Study	Geographical scope	Area of interest	Identification of participants	Nature of participants	Distribution method	N rounds	N participates invited	N Participants Round 1	Method used to select questionnaire items	Questionnaire format	Consensus method
Blow and Sprenkle (2001)	National	Common factors across theories of marriage and family therapy (MFT)	Member of organisation	Clinicians in the field of marriage and family therapy (MFT)	Mail	3	95	50	Not reported	Rating scale (1–7 scale) + open ended questions (Round 1)	Median and interquartile range
Cloosterman et al. (2013)	National	Characteristics of psychotherapeutic integration (PI) for depression in older adults	Known to researchers	Psychologists and psychiatrists with experience in psychotherapeutic integration (IP) with older adults	Email	3	Not reported	34	Literature review	Rating scale	Mean and standard deviation
Doughty (2009)	Not reported	Investigating the adapting grieving styles model of bereavement	Member of organisation; literature search	Grief counsellors and researchers in the field	Email	3	62	20	Literature review	Rating scale (1–5) + Open ended questions (Round 1)	Median and interquartile range
Edwards (2001)	International	Essential elements of multi-family therapy (MFT)	Review of the literature	Clinicians and researchers in the field of multi-family group therapy (MFGT)	Email	2	20	9	Literature review	Rating scale (1–5) + Open ended questions (Round 1)	Median and interquartile range
Gould (2011)	National	Cultural practices essential for cognitive-behavioural therapy (CBT) with Latino clients	Members of an organisation; known to researchers	Clinicians with experience of using the cognitive-behavioural therapy (CBT) approach with a Latino population	Email	2	475	33	Literature review + psychotherapy adaptation framework (PAMF)	Rating scale (1–5) + Open ended questions (Round 1)	Median and interquartile range
Jenkins (1996)	Not reported	Theory and practice of a reflecting team approach to family therapy	Review of the literature; journal editors; professional conventions	Family therapists with research and/or practical experience in the reflecting team approach.	Mail	2	29	26	Literature review	Rating scale (1–7 scale) + open ended questions (Round 1)	Median and interquartile range

Study	Geographical scope	Area of interest	Identification of participants	Nature of participants	Distribution method	N rounds	N participates invited	N Participants Round 1	Method used to select questionnaire items	Questionnaire format	Consensus method
McMurrin and Wilmington (2007)	National	Problem-solving therapy and psychoeducation for clients with a diagnosis of personality disorder	Unclear	Patients in a personality disorder unit.	Individual interviews	2	Not reported	12	Literature review	Rating scale (1–4 scale) + open ended questions (Round 1)	Percentage of agreement
Morrison and Barratt (2009)	National	Components of cognitive-behavioural therapy (CBT) for psychosis	List of clinical academics and trial therapists	Professionals who have worked in a research capacity implementing CBT for psychosis	Email	3	60	28	National guidelines and CBT-P adherence scales	Rating scale (1–5)	Percentage of agreement
Roos and Wearden (2009)	Not reported	To develop a working definition for “socialisation to the model” used in Cognitive Behavioural Therapy (CBT) model	Review of the literature	Clinical psychologists	Email	3	16	9	Not reported	Rating scale (1–5) + Open ended questions (Round 1)	Median and interquartile range
White et al. (1997)	National	To identify the principal components of marriage and family therapy (MFT)	Members of an organisation	Clinicians and researchers in the field of marriage and family therapy (MFT)	Mail	2	216	87	Not reported	Rating scale (1–5) + Open ended questions (Round 1)	Median and interquartile range

#### *2.4.4 Level of anonymity*

The means used to protect anonymity during the Delphi process were clearly reported in only four studies (Cloosterman et al., 2013; Edwards, 2001; Morrison & Barratt, 2009; Roos & Wearden, 2009). A further two studies (Gould, 2011; Jenkins, 1996) mentioned the importance of anonymity in their introduction, but did not elucidate whether it was adhered to in the study. The remainder of the studies neglected to report anonymity. In two studies, participants met with the researchers in person. For instance, in McMurren and Wilmington (2007), the whole Delphi process was conducted using interviews and it is unclear whether participants knew the identity of the other individuals. Furthermore, in Blow and Sprenkle (2001), following three rounds of questionnaires, six of the fifty participants were invited to take part in an interview to clarify responses, five by telephone and one by email. It may be assumed that anonymity was maintained, but, again, this was not reported in the paper.

#### *2.4.5 Analysis of qualitative data*

A summary of the methodological features of the Delphi studies are presented in Table 1. Eight of the studies used open-ended questions in their first round questionnaire. In two of the studies (Doughty, 2009; Edwards, 2001) the data from the first round was presented verbatim in the Round 2 questionnaire, meaning that a formal qualitative analysis was not necessary. However, of the remaining six studies in which qualitative data was collected, the process used to analyse the data was not clearly delineated in five of the six studies (Blow & Sprenkle, 2001; Gould, 2011; Jenkins, 1996; Roos & Wearden, 2009; White et al., 1999) and was not reported in one study (McMurren & Wilmington, 2007). Of the studies that partially reported the process, there was insufficient information for replication

in future research. For instance, Jenkins (1996) noted that responses from the Round 1 questionnaire were “edited for redundancy, then written as statements about reflecting team theory and practice” (p.223) and two independent raters checked one third of the statements. However, insufficient details were presented regarding the process used, and specifically whether methodological tools such as qualitative content analysis or thematic analysis were utilised.

#### *2.4.6 Use of rating scales*

A rating scale was used in all studies, with three different scale levels: a 5-point Likert scale was used in seven studies (Cloosterman et al., 2013; Doughty, 2009; Edwards, 2001; Gould, 2011; Roos & Wearden, 2012; Morrison & Barratt, 2009; White et al., 1997); a 7-point Likert scale was used in two studies (Blow & Sprenkle, 2001; Jenkins, 1996) and a 4-point Likert scale was used in one study (McMurran & Wilmington, 2007). The highest and lowest points of the scale used were reported in all but two studies (Cloosterman et al., 2013; Jenkins, 1996).

#### *2.4.7 How consensus was reached*

The attainment of consensus was a principal objective of all reviewed studies, of which an a priori definition was provided in each study (Table 3). The method adopted to consider if consensus was achieved varied: seven studies (Blow & Sprenkle, 2001; Doughty, 2009; Edwards, 2001; Gould, 2011; Jenkins, 1996; Roos & Wearden, 2009; White et al., 1999) used the median and interquartile range; two studies used percentage of agreement (McMurran & Wilmington, 2007; Morrison & Barratt, 2009) and one study used the mean and standard deviation (Cloosterman et al., 2013). However, six of the studies (Blow &



Sprenkle, 2001; Edwards, 2001; Gould, 2011; Jenkins, 1996; McMurran & Wilmington, 2007; White et al., 1997) used a dichotomous measure of consensus, whereby items that did not meet the criteria were excluded without a further round for participants to deliberate. However, the remaining four studies used a further round in which they presented participants with either all items from the previous round, accompanied by statistical information (Cloosterman et al., 2013; Doughty, 2009; Roos & Wearden, 2012), or items that reached marginal consensus (Morrison & Barratt, 2009), and invited participants to re-evaluate their own response.

**Table 2.** The reporting quality of the studies

Quality item	Blow and Sprenkle (2001)	Cloosterman et al. (2013)	Doughty (2009)	Edwards (2001)	Gould (2011)	Jenkins (1996)	McMurrin & Wilmington (2007)	Morris on & Barratt (2009)	Roos & Wearden (2009)	White et al. (1997)	Total %
1	2	2	2	2	2	2	2	2	2	2	100%
2	2	2	2	2	2	2	2	2	2	1	95%
3	2	0	2	2	2	2	0	2	2	2	90%
4	2	2	2	2	2	2	2	2	2	2	100%
5	2	2	2	2	2	2	2	2	2	2	100%
6	2	2	2	2	2	2	2	2	2	2	100%
7	2	0	1	2	1	2	0	1	1	1	55%
8	1	N/A	2	2	1	1	0	N/A	1	1	50%
9	1	1	2	2	2	1	2	2	2	2	85%
10	2	0	2	2	2	1	2	2	1	1	75%
11	2	1	2	1	2	1	0	2	2	1	70%
12	0	2	0	2	1	0	0	2	2	0	45%
13	2	2	2	2	2	2	2	2	2	2	100%
14	2	2	2	2	2	2	1	2	2	2	95%
15	2	2	2	2	2	2	2	2	2	2	100%
16	1	2	1	0	2	1	2	2	1	0	60%
17	2	2	2	2	2	2	2	2	2	1	95%
Total	26	24	30	31	31	27	23	31	30	24	28
%	76%	75%	88%	91%	91%	79%	68%	97%	88%	71%	82%

Aspect of Reporting	Specific Items for Which the Reporting Quality Was Assessed		Scale 2 = Clearly reported 1 = Partially reported 0 = Not reported /Not applicable
Preparation	1	Research question/aims	
Participants	2	How items were generated for first questionnaire	
	3	Number of participants invited	
Delphi Methodology	4	Characteristics of participants	
	5	How participants were identified/sampled	
	6	Administration of questionnaires (e.g. postal, email)	
	7	Information provided to participants prior to the first round	
	8	Analysis of qualitative data, if applicable	
	9	Details of rating scale, if applicable	
	10	What was asked in each round	
	11	Feedback to participants after each round	
Results	12	Level of anonymity	
	13	A priori definition of “consensus” about whether an item should be measured/dropped	
	14	Number of respondents invited to each round	
	15	Number who completed every round	
	16	Results/distribution for each item scored in each round	
	17	List of all items that participants agreed should be considered	

**Table 3.**

Summary of Delphi items that achieved consensus

Study	Definition of consensus	Initial number of items	Items that reached consensus (%)
Blow and Sprenkle (2001)	Items that received a median rating of 6 on a 7-point Likert scale and an interquartile range of 1.50 or less.	333	80 (24%)
Cloosterman et al. (2013)	Consensus was met if two of the three criteria met: a mean items score of at least 3.66, item with a standard deviation of $\leq 1$ and 2/3 majority of participants answering “agree” or “fully agree”	52	34 (65%)
Doughty (2009)	Items that had an interquartile range of equal or less than one	58	21 (36%)
Edwards (2001)	Items that had a median importance of at least 4.5 on a 5-point scale and an interquartile range of equal or less than 1.0.	219	35 (16%)
Gould (2011)	Items achieved consensus if they a median of 4.00 and an interquartile range of 1.50 or below.	269	33 (12%)
Jenkins (1996)	Items with a median of less or equal to 2 and with an interquartile range of less than or equal to 1.50 were accepted.	273	48 (18%)
McMurran et al. (2007)	Items were included that achieved when 70% or more participants concurred in their views, whether in agreement or disagreement.	89	89 (100%)
Morrison and Barratt (2009)	If at least 80% or above of participants rated an item as essential or important.	134	69 (51%)
Roos and Wearden (2009)	Items with an interquartile range (IQR) of equal or less than 1, with an IQR of 0 indicating perfect consensus.	11	5 (45%)
White et al. (1997)	Items that were included in the study if their median importance was 4.50 or greater and their interquartile range was 1.00 or greater.	771	217 (28%)*

\* = items were collapsed in 34 clusters

#### 2.4.8 Delphi results

The Delphi process resulted in expert consensus being reached on items in all studies (Table 3). However, the reporting quality of the results varied. Certainly, the number of participants who completed each round was well reported in all studies. The final list of items that met consensus was reported in eight studies and partially reported in two (White et al., 1997; Roos & Wearden, 2012); however, only four studies (Cloosterman et al., 2013; Gould, 2011; McMurran & Wilmington, 2007; Morrison & Barratt, 2009) documented all items that were rated in each round, either in the text or in an appendix.

All four of the studies presented the items in a table format accompanied by different information. Cloosterman et al. (2013) displayed a table containing the items that reached consensus, which round consensus was achieved – or not achieved – and how many participants responded to each item. In another study, Gould (2011) presented all items accompanied by the mean and interquartile range. While Morrison and Barratt (2009) displayed the results in two tables, one for the items that achieved consensus and another for the items that were excluded; in both tables, each item was accompanied by information about the round in which it was included/excluded and an indication of whether it was a CBT-specific item or a general psychotherapy item. Finally, McMurran and Wilmington (2007) displayed all items accompanied by a percentage of agreement for each item.

Concerning the six studies that did not report the full list of items rated, two studies (Doughty, 2009; Jenkins, 1996) just displayed the items that reached consensus. Doughty (2009) presented the items in a table, each item accompanied by the median, interquartile range and the participant (represented by a number) who contributed the item. Similarly, a further two studies (Blow & Sprenkle, 2001; Jenkins, 1996) presented the items that reached consensus in tables representing different categories, all accompanied by the median and interquartile range. White et al. (1999) stated that 217 variables achieved consensus in the study; however, in the paper they were collapsed into five categories and a further 34 “conceptual clusters” that were described within the text. While Edwards (2001) displayed only the consensus items that had been rated by participants as being “essential” in a table format – however, all the items were displayed in the Round 2 questionnaire found in the appendix. In Roos and Wearden (2012), the reporting of the results differed depending on the initial questions asked. For their question what is “socialisation to the model” in CBT, they presented a definition, which they reported was made up of those

items rated as “essential” and “important” that achieved consensus (interquartile range of  $\geq 1$ ), whereas the five key indicators of “socialisation to the model” that achieved consensus were presented in a table.

## **2.5 Discussion**

The present systematic review aimed to critically appraise the use and reporting quality of studies that used the Delphi method to develop knowledge on psychotherapeutic models: for instance, the clarification of therapeutic techniques, modifications for use with different populations, or the consolidation of opinions on what represents best practice. Ten studies were selected, covering a range of psychotherapeutic models across different populations. The reporting quality was generally respectable, especially in relation to the preparatory stages. However, some aspects of the Delphi methodology important for interpreting the results were not consistently reported. Moreover, it was unclear in some studies whether the core principles of the Delphi method (anonymity between participants, iteration, controlled feedback and statistical group response) were considered. All the studies reported the attainment of consensus as a primary objective, with all achieving consensus in accordance with their research aims. The criteria used to rate the quality of the studies were based on two prior systematic reviews of the application of the Delphi method in two different research areas: for selecting healthcare indicators (Boulkedid et al., 2011) and to determine outcomes to measure in clinical trials (Sinha et al., 2011).

### **2.5.1 Questionnaire development**

The flexibility of the Delphi method design means it can be adjusted depending on the aims and objectives of the study; however, this can sometimes result in a decline in methodological rigour (Powell, 2003), especially considering the absence of universal

guidelines. One area of the methodology that is commonly adapted is the round one questionnaire; studies applying the classic Delphi method often consider this an explorative stage where open-ended questions are used. In the present review, studies used two different methods: the first involved the researchers developing a structured questionnaire based on a review of the literature or on existing guidelines; the second entailed presenting open-ended questions to the participants to elicit their opinions. Whichever approach researchers choose, it is important that it is congruent with the research objectives, and that the approach chosen is implemented and reported in a scientific manner allowing for the process to be replicated by other researchers (Creswell, 2013). However, of the studies that generated qualitative data from the questionnaire process, the method of data analysis was only clearly reported in 20% of the studies. Furthermore, none of the studies that collected qualitative data referred to a specific qualitative analysis technique used, such as content analysis or thematic analysis. This was surprising for a number of reasons: 1) the importance of using formal qualitative analysis techniques has been documented in the literature (e.g., Hasson et al. 2000; Iqbal & Papon-Young, 2009); 2) without rigorous analysis, the credibility of the interpretation of the expert responses could be undermined, which could affect the overall impact of the study; and finally, 3) a lack of transparency of the approach used could hinder future replicability and repeatability of the study (Golafshani, 2003).

### 2.5.2 *Consensus*

Consensus was a primary objective of all the studies considered in the present review. There is no universally agreed measure of consensus in the literature, thus, it was not surprising that the predefined consensus threshold differed across studies. The majority

of studies used the median and the interquartile range to measure consensus (70%), while percentage agreement of scores and the mean and standard deviation were also used. However, despite consensus being achieved in all studies, the iterative feature of the Delphi method was not used in the traditional sense in some studies. That is, some studies did not permit participants to review their responses in light of the group response to items, whether this involved all the items being presented or items that fell just below the consensus threshold. For instance, of the four studies that took this approach in the present review (Edwards, 2009; Gould, 2011; Jenkins, 1996, White et al. 1997), the percentage of items that reach consensus from the initial number of items were remarkably low, ranging from 12% to 28%. Conceivably, allowing the participants to re-consider items that reached a marginal level of consensus may have resulted in further items being accepted. While there may be a good rationale for these decisions – such as time constraints or potential participant attrition rates –, these reasons should be referenced in the article.

Of course, modification of the technique depending on the research questions is accepted in the literature (Adler & Ziglio, 1996; Linstone & Turoff, 1975); however, deviations from the core features that are not systematic and rigorous may diminish the overall results (Keeney et al., 2006). Indeed, some researchers argue only studies that adhere to the core principles (anonymity, iteration, controlled feedback and statistical group response) should be classified as a Delphi study (Rowe & Wright, 1999). Therefore, it is imperative that adaptations to the methodology are based on empirical evidence and that the justifications are clearly communicated to the reader in order not to undermine the results of the Delphi method.

The composition of experts on a Delphi panel is fundamental to the validity of the results (De Villiers et al., 2005). Therefore, it is essential that the selection of experts and the criteria upon which this is based be clearly delineated in the study text. In that regard, this was clearly reported in all of the studies in the present review. Another important feature of the classic Delphi is the anonymity between participants. As previously mentioned, if this is not adequately addressed this could lead to social pressures influencing the results (Rowe & Wright, 1999); however, surprisingly, anonymity was only clearly reported in 40% of the studies. While it is accepted that in a modified Delphi method, where interviews are completed with participants, it may not be possible to ensure full anonymity, this still needs to be clearly justified and reported in the text. Of course, the fact that this was not adequately reported in some studies does not mean that it was not considered by the researchers.

### *2.5.3 Strengths and limitations of the review*

A strength of the current review is the comprehensive systematic search strategy that was based on the PRISMA guidelines, which included both published articles and unpublished PhD dissertations. This inclusion should have helped reduce publication bias. Indeed, two of the three papers with quality ratings of over 90% were unpublished PhD dissertations (e.g., Edwards, 2001; Gould, 2011). Another strength of the review was the transparency of the review process: a detailed quality criteria and extraction template were developed based on prior research to address the present review questions. A further strength of the present review was that 60% of the studies selected for inclusion were randomly assessed for methodological reporting quality by a second independent rater, with a high level of inter-rater reliability established. While there is still a chance of



subjective bias, this process enhanced the reliability of the decision-making during the quality assessment process.

There are also a number of limitations to the present review. Firstly, as there is yet no agreed quality criteria for considering studies that use the Delphi method, the present review developed quality criteria and an extraction template based on two prior systematic reviews that assessed the reporting quality of the Delphi method in other areas of research (Boulkedid et al., 2011; Sinha et al., 2011). While there are large variations in how the Delphi method is applied in the literature, it was felt that the review criteria developed were justifiable in terms of the features of the Delphi process appraised. For instance, in the present review, a quality criterion that appraised the reporting quality of qualitative methods used was added, which was not present in the two prior systematic reviews. It was felt that this was important to appraise, especially considering it was detailed as important in the Delphi method literature; however, other researchers may disagree with this decision. In addition, there was also a limitation given that the review excluded papers not written in the English language, which may have resulted in language or cultural bias through omitting relevant studies. Furthermore, the lack of universal guidelines concerning the application of the Delphi method means there is great variation in how important areas of the Delphi are implemented, for example, the definition of consensus. Therefore, the present review did not directly evaluate the methods selected by researchers, but rather, the review focused on the reporting of quality of the method chosen by the researchers. Despite this decision being consistent with the two prior systematic reviews, this may be considered a limitation. In the future, should there be more agreement in the literature on, for example, what is the best method to calculate consensus, then this should be evaluated more directly in future reviews.

#### 2.5.4 *Conclusion*

This review considered the methodological reporting of studies that used the Delphi method to develop knowledge on psychotherapeutic models. The reporting quality was generally satisfactory in most areas of the Delphi method process, particularly compared to previous reviews that examined the Delphi method in other research areas. For instance, there were areas that were clearly reported by all or almost all studies: the rationale for using the Delphi method, the reporting of information about participants and information about the consensus criteria. However, there were areas where the reporting was inconsistent where improvements are required. For example, the reporting quality of communication with the participants, reporting of anonymity, analysis of qualitative data and the reporting of all items rated by participants needs to be improved in future Delphi studies.

Based on the results of the present review, there are a number of considerations for researchers considering using the Delphi method in the area of psychotherapy. Firstly, during the preparation phase of the Delphi method, it is important that the research problem is clearly clarified and that the rationale for using the Delphi method is outlined. In addition, during this phase it is also important to consider the size and composition of the panel of experts (e.g., heterogeneous or homogeneous sample), which should include a clear and justified expert criteria that outlines the background of all participants. Furthermore, the mode (e.g., email or mail) and the amount of communication with participants need to be considered to ensure they know what is required to reduce attrition rates. Next, the method of consensus needs to be outlined in relation to the studies aims. With regard to the methodology, decisions need to be made in relation to, what is the most

appropriate design of the first round questionnaire (adhering to principles of questionnaire design), how to analyse qualitative (e.g., specific qualitative analysis techniques) and quantitative data and what information is presented to participants between rounds (i.e., questions asked and feedback and statistical information presented to participants). Further, in relation to the results and their interpretation, there are a number of areas that need to be considered: the number of participants invited and the number that completed each round need to be reported; an explanation of why the Delphi process was ended (i.e., was it ended when consensus was met?) and a list of the total items and the items that reached consensus, ideally accompanied by statistical information (e.g., group response to each item), should be reported. Finally, throughout the whole Delphi process, it is essential that the methodology selected is meticulously and robustly executed and the decisions made are clearly reported in the research text to safeguard the validity and reliability of the results.

In summary, the Delphi method is a powerful tool for achieving consensus where a lack of clarity exists. The studies in the present review used the method to elucidate a number of different areas of psychotherapeutic models: improving practice guidelines, clarifying what model components are important for different clinical presentations, populations and client groups. If applied rigorously and in a correct manner the Delphi method could be used to provide useful insights into aspects of psychotherapeutic models to help improve current practice by providing outcomes which may inform practice guidelines or reveal gaps in the literature where further empirical inquiry may be necessary.

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### 3. Journal Article

#### Title page

A consensus approach towards identifying pertinent therapist characteristics in Good Lives

Model treatment: A Delphi study

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### **3.1. Abstract**

The Good Lives Model (GLM) is a novel, strengths-based offender rehabilitation framework, the principles of which are increasingly being integrated into sexual offender treatment programmes. The aim of the present study was to use expert opinion to explore how therapist characteristics, previously identified as important in sexual offending treatment, might be reflected in GLM-consistent treatment. Twenty-eight GLM experts, from five different countries, completed a three-round Delphi method. Experts endorsed 71 items reflecting the GLM ethos and principles in treatment, listed between twelve categories. This study represents a positive first step in research describing therapist characteristics in GLM-consistent treatment. Future research may explore how to incorporate these findings into GLM integration guidance, training and evaluation practices.

**Declaration of interest:** None

**Keywords:** Good Lives Model, therapist characteristics, Delphi method, content analysis

### **3.2. Introduction**

In recent years, offender rehabilitation has seen a theoretically informed shift from a deficits-based approach to one that explicitly considers the strengths and wellbeing of the individual. The Good Lives Model (GLM; Laws & Ward, 2011; Ward & Stewart, 2003) represents a pioneering strengths-based rehabilitation framework, the principles of which are increasingly being integrated into sexual offender treatment group programmes (e.g., Harkins, Flak, Beech, & Woodhams, 2012; Willis, Ward & Levenson, 2014). Considering that the operationalisation of the Good Lives Model into practice is still in its formative years, it is important that it be implemented consistently and in a skilled manner by therapists.

Research suggests that adherence to a treatment model, through selection, training, manuals and supervision is associated with positive treatment outcomes (Andrews & Dowden, 2005; Mann, 2010). In addition, positive therapist characteristics have been empirically associated with positive treatment change in sexual offender treatment (see Marshall, 2005). While treatment guides (e.g., Yates, Prescott & Ward, 2010) and more general guidelines for incorporating the GLM into treatment programmes (e.g., Willis, Yates, Gannon, & Ward, 2013) exist to help safeguard adherence to the model, there is as yet no research exploring whether therapist characteristics previously identified as important in sexual offending treatment might be reflected differently in GLM-consistent treatment (GLM-CT). This may be especially important given the model's progressive theoretical underpinnings. Therefore, the present study aims to build on extant research by using a Delphi method to explore expert opinion on how therapist characteristics (including personal qualities and use of skills/techniques) reflecting GLM principles and treatment ethos might be presented in treatment.

### 3.2.1. *The Good Lives Model*

Before summarising the GLM, it is important to give a brief outline of the model that the GLM improved upon, the Risk-Needs-Responsivity model (RNR; Bonta, & Andrews, 2010; Andrews & Bonta, 2006). In brief, the RNR model advocates that treatment should be guided by three core principles: a) the level of intervention should correspond to the individuals' level of risk (*Risk principle*); b) treatment should focus on criminogenic needs - dynamic risk factors empirically associated with recidivism (*Need principle*) and c) the intervention delivery should be responsive to different learning styles and abilities (*responsivity*) (Bonta & Andrews, 2010). These principles act as a guide for treatment; the therapeutic model empirically endorsed to address treatment targets is a cognitive behavioural-therapy (CBT) approach (Hanson et al., 2002). In practice this involves developing clients' insight into the function of thoughts and behaviour in their offending and teaching them to recognise the antecedents of offending and to use more adaptive strategies to circumvent risky situations more effectively (Jeglic, Maile, & Calkins-Mercado, 2010). The RNR model represents a highly influential model of sexual offending that has been significantly linked with a reduction in recidivism (e.g., Hanson et al., 2009). Nevertheless, in recent years, researchers have questioned its sole focus on risk, with the GLM representing a powerful theoretical justification for this shift (Laws & Ward, 2011; Ward, Yates & Willis, 2012). The GLM was designed to augment the RNR model; that is, it incorporates all its principles but argues that goods promotion should be given at least equal weight as criminogenic needs, with the weighting being adjusted based on an individuals' risk (Ward, Yates, & Willis, G. M, 2012).

The GLM offers robust theoretical justification for this point of divergence from the RNR. Specifically, the GLM argues, drawing on theoretical assumptions derived from biological, psychological, social and anthropological research (e.g., Ward & Brown, 2002), that to motivate and engage offenders in their rehabilitation journey, treatment needs to supplement risk management with a focus on clients' strengths and well-being (Ward, 2002; Ward & Stewart, 2003). Central to this thesis is the idea that all humans are goal-directed and naturally inclined to pursue a number of primary goods (Ward & Gannon, 2006). Presently, there are 11 different primary human goods that are suggested as being important: life (including healthy living and optimal physical functioning, sexual satisfaction); knowledge; excellence in work (including mastery experiences); excellence in play (including mastery experiences); excellence in agency (i.e., autonomy and self-directedness); inner peace (i.e., freedom from emotional turmoil and stress); relatedness (including intimate, romantic and family relationships); community; spirituality (in the broad sense of finding meaning and purpose in life); happiness and creativity (Willis et al., 2014). In the GLM, dynamic risk factors or criminogenic needs are reframed as obstacles to the achievement of primary goods, referred to as secondary goods. For instance, the primary good of relatedness might be met through secondary goods such as being in an intimate relationship or being part of a social group; however, in the case of an offender, primary goods may be sought through unlawful means or secondary goods, such as through intimacy with a child (Ward & Brown, 2004). Therefore, in practice, the GLM translates into a focus on supporting clients to develop the necessary skills and capabilities to meet these primary goods through appropriate means, thus empowering them to build a meaningful and fulfilled life while consequently reducing risk (Ward & Brown, 2004). The tasks for therapists, therefore, are to work collaboratively with the client to shape their goals and strategies to achieve their



primary goods in a pro-social and meaningful manner. This is delineated in a good lives plan: an evolving document to guide clients' treatment and broader rehabilitation journey.

### *3.2.2. Therapist characteristics*

Therapist characteristics and group process have both been associated positively with change in sexual offending treatment (Beech & Hamilton-Giachritsis, 2005; Marshall, 2005) and are, therefore, undoubtedly important to consider in GLM-consistent treatment (GLM-CT). For instance, in a recent evaluation of GLM operationalisation in the United States, Willis et al. (2014) noted delivery practices congruent with the GLM were positive therapist characteristics, collaboration with clients and attention to individual client goals; in regards to practices inconsistent with the GLM, they noted the rigid use of manuals, classroom-style delivery and displays of confrontation. The therapist characteristics that they rated as important came from a seminal series of studies by Marshall and colleagues (Marshall & Serran, 2004; Marshall et al., 2003a; Marshall et al., 2002) examining the influence of therapeutic characteristics in sexual offender treatment. Marshall et al. (2003), based on an extensive review of the psychotherapy literature, devised a scale to rate observable therapists' characteristics in group format using videotaped sessions from HM Prison Service's Sex Offender Treatment Programme (SOTP). They identified ten therapist characteristics (empathy, warmth, rewarding, directive, appropriate body language, appropriate amount of talking, appropriate voice tone, encourages participation, asks open-ended questions, deals effectively with problems) that were considered important. In a further study, they found that four therapist characteristics (empathy, warmth, rewarding style and level of directiveness) were related to positive change in treatment (Marshall et al.,

2002). Conversely, they found that harsh confrontation was negatively linked to treatment change.

However, the therapist characteristics were validated using videotapes from an SOTP programme that was rigidly manualised. Despite the fact that trained observers were able to establish enough variability in therapist behaviours to allow them to be recorded, the highly manualised nature of the programme may have diluted the display of therapeutic characteristics (Marshall et al., 2003). While there is a convincing argument that manuals in sexual offender treatment can accommodate therapeutic style while safeguarding the integrity of an intervention (Mann, 2009), in the case of the GLM it has been suggested that treatment programmes integrating its principles and ethos are best represented through a “treatment guide” approach, allowing for greater tailoring of the intervention to clients’ good lives plans (Willis et al., 2013). This format would arguably require more flexibility and creativity on the part of the therapist, resulting in therapist characteristics being represented in a different manner, or more emphasis being placed on therapeutic style within sessions.

Since the increase in strengths-based approaches to sexual offender treatment, Fernandez and Mann (2010), based on a review of the literature, presented a number of important therapist competencies for effective intervention with sexual offenders. They made the distinction between basic competencies and advanced competencies, with a clear emphasis on increasing self-esteem, hope and client motivation. Examples of additional therapist skills and characteristics included understanding and acceptance of clients, using positive language, generalising change beyond the treatment room and using group processes (Fernandez & Mann, 2010). These positive therapist characteristics are certainly important in GLM-consistent treatment (GLM-CT). Indeed, Willis and Ward (2012) highlight

the importance of Motivational Interviewing techniques (MI; Miller & Rollnick, 2012) and the use of future-oriented and optimistic language in GLM-CT. These characteristics will require therapists to be more mindful of their language use, not just in terms of using hopeful and encouraging communication, but also in relation to change and future-focused language, which has been associated with positive outcomes in MI-based interventions in the addictions literature (e.g., Apodaca & Longabaugh, 2009).

Some researchers have questioned whether the GLM is advocating a non-directive delivery approach more akin to the humanistic traditions (e.g., Rogers, 1957), which they caution is counter to the directive and structured CBT-based approach suggested in the literature (Looman & Abracen, 2013). In response, Willis et al. (2012) have elucidated in more concrete terms how the GLM might be integrated with the RNR model and CBT – in doing so, they referenced the therapist characteristics in the Marshall studies (Marshall, 2005) as being important. More recently, Willis et al. (2014) specifically acknowledged the importance of directiveness amongst the positive characteristics important in GLM operationalisation; however, they did not allude to whether this might be displayed differently in GLM-CT. Certainly, the overuse of directiveness has been cautioned against in sexual offender treatment (Marshall & Serran, 2004). It is recommended that it should only be used when a client is struggling to resolve an issue (Marshall & Serran, 2004) and balanced with the use of reflection and open-ended questioning (Serran et al., 2003). Nonetheless, given the GLM principles place more emphasis on client agency and autonomy, with autonomy and self-directedness also considered part of the primary good of excellence in agency (Ward, Mann, & Gannon, 2007), the use of directiveness in GLM-CT may need further clarification.

### *3.2.3. Conclusion*

The GLM is a novel offender rehabilitation framework, the principles of which are increasingly being operationalised into sexual offending programmes internationally. The model is compatible with the RNR model and CBT. However, its theoretical underpinnings place more importance on clients' well-being, strengths and agency, thus making therapeutic characteristics more central in treatment. Whereas there is helpful guidance (Willis et al., 2012) and a detailed evaluation of operationalisation of the GLM in practice in the United States (Willis et al., 2014), there is not yet any research examining whether therapist characteristics might be displayed differently in GLM-CT and how this might be represented in treatment sessions.

### *3.2.4. Research aims*

The principal aim of the present study was to explore and identify, by expert opinion, what therapist characteristics are important in GLM-consistent treatment (GLM-CT) and how they might be recognised in treatment. The study also aimed to propose the identified items as a starting point for a therapist fidelity framework to help with evaluation and to safeguard standards in treatment.

## **3.3 Method**

The present study was explorative in nature. A three-round Delphi method was selected to achieve the objectives of the present study.

### *3.3.1. Delphi method*

The Delphi method is a consensus development methodology that aims to converge opinion on a topic with a group of experts without the need to bring the group together (Petry,

Maes & Vlaskamp, 2007). The Delphi method allows for the exploration of emerging research areas, helping to identify where a lack of clarity may exist (Hasson, Keeney, & McKenna, 2000). Therefore, the method lends itself well to the exploration by expert opinion of how therapist characteristics reflecting the GLM ethos and principles might be recognised in GLM-CT, especially considering its early stage of operationalisation. The first Round of the Delphi method often uses open-ended questions to allow panellists to “brainstorm” ideas (Skulmoski, Hartman & Krahn, 2007). The second round is constructed from the data from Round 1 and is more specific; here, the statements are often presented in the form of a structured questionnaire where experts rate the importance of the statements (Hultsjö, Berterö, Arvidsson & Hjelm, 2011). The third round often involves participants being presented with their own responses as well as responses of other participants on items where consensus was not agreed. Should consensus not be met, further rounds are required, generally taking the same format as the Round 3 questionnaire (Morrison & Barratt, 2010; Yap, Pilkington, Ryan, Kelly, & Jorm, 2014).

### *3.3.2. Panel formation*

As the expert opinions are the foundation upon which the result of a Delphi method are based, the selection of experts is critical to the strength and validity of a Delphi study (Clayton, 1997; Skulmoski et al., 2007). Therefore, a purposive sample of experts was carefully selected for the present study using the following eligibility criteria:

- Had published at least one article, chapter or book with the GLM being the main focus in the last three years; and/or
- Had worked in a managerial or supervisory role on GLM-based treatment programmes in the last three years.

The number of experts needed to make up a panel can vary considerably depending on the area of interest and the time and resources available to the researchers (Iqbal & Pipon-Young, 2009). However, it has been recommended that with a homogenous group a sample size of 10–15 should yield respectable results (Adler & Ziglio, 1996; Okoli & Pawlowski, 2004). Given that not all experts would be available and that attrition between the rounds was likely, a large purposive sample of experts with research and/or practical experience with the GLM (N = 81) was contacted for the current study. To establish a broad sample of experts, the authors considered a number of sources. In the first instance, the authors consulted the GLM website ([www.goodlivesmodel.com](http://www.goodlivesmodel.com)), which lists key international researchers in the field (N=12). Next, a review of the GLM literature was conducted, from which first and second authors of GLM articles were considered for the study (N=16). Furthermore, area representatives from the National Organisation for the Treatment of Abusers (NOTA), Australia New Zealand Association for the Treatment of Sexual Abuse (ANZATSA), and the Association for the Treatment of Sexual Abusers (ATSA) were contacted to solicit further experts (N=2). With regard to GLM practice experts, individuals who were known to the researchers from special hospital, prison and community settings using GLM-CT programs were contacted (N=15), the majority of whom were from the United Kingdom. Further experts were identified through a 'snowballing exercise' (Skulmosk et al., 2007) which involved all experts who were contacted being asked to identify further potential experts based on a definition provided by the researchers (N=36).

### *3.3.3. Participants*

In total, twenty-eight participants took part in the Delphi survey. Participants were from The United Kingdom (N=19), Canada (N = 2), New Zealand (N = 3), Australia (N = 3) and The

Netherlands (N = 1). Round 2 was completed by 27 (96%) individuals and Round 3 was completed by 22 (79%) individuals. The panel included some of the key international GLM researchers. Out of the 28 participants, eight were academic professionals, twelve were forensic psychologists, four were clinical psychologists, one was a CBT therapist and three were trainee forensic psychologists with GLM treatment manager experience. Given that the whole Delphi method process involved a commitment to the study in excess of six months, involving the three rounds of organised questionnaires, the response rate was thought to be satisfactory.

#### *3.3.4. Procedure*

Identified participants were sent an email detailing the study that included a link to the survey, designed using SelectSurvey.net (Round 1 and 2) and Smartsurvey.co.uk (Round 3). If participants chose to continue, they were provided with a rationale for the study and an outline of the study procedure (Appendix E). It was made clear that anonymity between participants would be ensured. Consent to participate was given electronically. Three weeks after the initial email was sent, researchers sent a reminder email (Appendix F) to participants with a link to the survey. Following the distribution of the Round 2 and Round 3 questionnaires, an additional reminder email was sent to participants one week before the deadline. Participants that did not respond were not invited to further rounds. Participants were given between four and five weeks to complete each round.

There is no agreed level of consensus in the literature (Heiko, 2012). Therefore, for the present study, consensus criteria used by Langlands, Jorm, Kelly and Kitchener (2008) and Morrison and Barratt (2010) were used to decide which items to include and exclude based on a defined average percentage of agreement. However, considering the small

sample size and the homogeneous nature of the topic, an 85% cut-off was used as opposed to an 80% cut-off used in Langlands et al. (2008) in order to ensure the methodology was adequately sensitive to divergent opinions. The consensus criteria were as follows:

1. If at least 85% or above of participants rated an item as essential or important in GLM-CL, the item was included.
2. If 75–85% of participants rated an item as essential or important in GLM-CT, participants were asked to re-rate the item in Round 3.
3. Any items that did not meet conditions 1 and condition 2 were excluded.

#### *3.3.5. Round 1 questionnaire*

Round 1 (Appendix G) was an open-ended questionnaire (Iqbal & Pipon-Young, 2009; Hsu & Sandford, 2007) that adhered to the principles of questionnaire design, especially concerning the wording of the items (Barker, Pistrang, & Elliott 2002). Pilot testing was completed by six individuals to determine a timeframe for completion and the readability of the questions. The first section was concerned with therapist characteristics considered important to monitor in order to safeguard faithfulness to the GLM principles. It included two questions to solicit participants' responses: "What facilitator characteristics do you think are important to consider in GLM-based treatment interventions?" and "How might the facilitator qualities you identified be recognised and/or demonstrated in a group session?" The second section was more circumscribed and presented participants with 13 facilitator characteristics recommended in sexual offending treatment programmes more generally (e.g., Fernandez & Mann, 2010; Marshall, 2005; Marshall & Serran, 2004), such as "displays warmth" and "use of reinforcement", and asked how the characteristics might be demonstrated by facilitators in GLM-CL specifically.



### 3.3.6. *Content analysis*

Content analysis was used to analyse the qualitative data within the Round 1 questionnaire, based on Graneheim and Lundman (2004). Content analysis is a structured research method that can be used to condense a large body of data into fewer categories, based on a specific coding procedure (Krippendorff, 1980). As the present study was concerned with describing the manifest content of the written data from the Round 1 questionnaire, it was decided that content analysis was the most appropriate research tool to analyse and organise the data.

To begin with, participants' responses from the questionnaire were transferred from an Excel document into a single standardised format in a Word document. The data were read through in full several times to become familiar with their general meaning in relation to the study objectives (Thomas, 2006). The unit of analysis was the participants' responses to the open-ended questions as a whole. This was decided upon as both sections had the same key focus: therapist characteristics that reflect the GLM principles in treatment. In line with the study objectives, the analysis was concerned with manifest meaning units consisting of words and phrases. The text segments varied from one or two-word answers to longer paragraphs that contained a number of meaning units. Moreover, the meaning units were further condensed to make the text more precise while keeping the meaning intact. The condensed meaning units were assigned different colour codes to differentiate examples of positive and negative practice: green for positive and red for negative. Meaning units with similar meanings were assigned categories and sub-categories, and were then grouped into broader themes (see Appendix H). This process was repeated with the aim of reducing the number of categories and sub-categories by collapsing those that were similar into higher order categories and sub-categories (Elo & Kyngäs, 2008).

Frequency and percentages of codes were assigned to each specific category. By way of this process, the categories were developed from the data. However, it should be noted that although frequency of the codes were counted in each category (Appendix I), this was not intended to suggest that the categories with the highest frequency were the most important therapist characteristics for GLM-CL, as is sometimes the case in content analysis (e.g., Chambers & Chiang, 2012). The inter-rater agreement statistic (Kappa) was calculated for 20% of the data from the Round 1 questionnaire using SPSS V22 for Windows. The result yielded a score of .78, which indicates a substantial level of agreement (Viera & Garrett, 2005). Discrepancies were discussed, and, where appropriate, the categories were adjusted.

#### *3.3.7. Round 2 questionnaire*

The results from the content analysis were combined to create the items for the Round 2 (Appendix J) questionnaire (Iqbal & Pipon-Young, 2009). Consistent with the study aims, items that could not be observed objectively were excluded. For instance, the sub-categories “self-awareness”, “work-life balance” and “emotional resilience” – although important in GLM-CT treatment – were not deemed to be therapist characteristics that could be observed in a treatment session and were, therefore, excluded from Round 2. Furthermore, in order to make items into a sentence representing therapist characteristics relating to the category heading, the researchers added prefaced words to some items where necessary. For instance, in the boundaries and co-facilitation modelling category, the sub-category from the content analysis “good professional boundaries” was prefaced with the word “demonstrates” and accompanied by three examples of relevant behaviours offered by participants. Items were then discussed between the researchers in terms of comprehensibility and were amended as necessary.

As with the previous round, pilot testing was completed by six individuals in order to determine a timeframe for completion and the readability of the questions. The Round 2 questionnaire comprised 76 items that represented positive and negative facilitator characteristics that were identified by participants as representing GLM principles in treatment. Each item was listed under a category heading based on the content analysis of the Round 1 data. Participants were asked to rank the strength of their agreement for each item on a 5-point Likert Scale (5, essential; 4, important; 3, do not know/depends; 2, unimportant; and 1, should not be included) based on Morrison and Barratt (2010). Additionally, there was a comment box at the end of the questionnaire where participants could qualify their answers or communicate any supplementary information to the researchers. Once all of the responses had been collected, the consensus criteria were applied and items were grouped into those to be included, excluded, and re-evaluated.

#### *3.3.8. Round 3 questionnaire*

All 26 participants who completed Round 2 were invited to take part in Round 3 (Appendix K), and 23 agreed. In Round 3, participants were presented with their own responses as well as responses of other participants on items where consensus was not agreed – items that 70%–79% of the participants rated as essential or important in Round 2 ( $n = 10$ ) – and asked if they would like to re-evaluate their response. The format for the questionnaire was slightly different, based on feedback from Round 2: rather than having a comment box at the end of the questionnaire, there was a comment box after each item.

### **3.4. Results**

#### *3.4.1 Results of content analysis*

The Round 1 questionnaire was completed by 28 participants, which resulted in 954 codes (Appendix I). The codes were arranged into 14 different categories and 86 sub-categories that were grouped into five themes: therapeutic style, facilitation style, GLM in practice, responsivity, and other. Each of the five themes will be described below and are illustrated in Figure 1.

#### **Therapeutic style**

Theme one, “therapeutic style”, related to codes and categories associated with therapeutic characteristics: therapist factors that are considered to influence the effectiveness of treatment (Marshall, 2005). The categories in this theme were “being warm, genuine and respectful”; “exploration of session material”; “appropriate encouragement and reinforcement”; “boundaries and co-facilitation modelling”; “appropriate body language and presentation” and “challenges participants in a supportive manner”. As might be expected, the majority of the codes were in agreement with the therapist characteristics identified as important in sexual offender treatment by Marshall and colleagues (Marshall et al., 2003). In relation to GLM-CT specifically, the codes echoed the importance of consistently reinforcing future-focused language and relating material to individuals’ good lives plans on a regular basis throughout treatment. Additionally, the use of motivational skills was evident in this category. Furthermore, negative codes in this theme revolved around being confrontational, which has been negatively associated with achievement of goals in sexual offending treatment (Marshall et al., 2003; Willis et al., 2012).

## **Facilitation style**

Theme two, “facilitation style”, was related to therapist skills that, in essence, guide the session in a professional and respectful manner and ensure group members are engaged and focused. The categories that made up this theme were “conducting the session” and “monitoring and sharing progress”. The codes in these categories were generally in line with what would be expected from a competent group facilitator. There was, however, an emphasis on session flexibility: specifically, suggestions that therapists should not be overly focused on a treatment manual; instead, it was suggested that they should be flexible to attend to the needs and suggestions of group members. As previously mentioned, in GLM treatment the individual good lives plan of each client is an important part of treatment and, therefore, the approach does not encourage rigidly planned sessions (Willis et al., 2012).

## **GLM in practice**

The third theme, “GLM in practice”, contained two different categories: “Good lives planning: balanced focus on avoidance and approach goals” and “Practical knowledge and understanding of GLM principles”. This was primarily concerned with how therapists’ knowledge of the GLM principles transfers into practice. The first category comprised codes that were related to GLM planning and the development of clients’ good lives plans: that is, the therapist skills concerned with collaboratively working with clients to explore and elucidate primary goods and associated approach goals. Additionally, the codes in this category emphasised a balanced focus on approach and avoidance goals (or criminogenic needs).

The second category, “practical knowledge and understanding of GLM principles”, as the name indicates, comprised codes that reflected the core principles of the GLM – in particular, communicating through attitudes and behaviours that the GLM is relevant to everyone and insuring a consistent strengths-based focus. Some of the codes relating to knowledge and understanding in this category, although pertinent, might be difficult to objectively observe in treatment sessions.

### **Responsivity**

The fourth theme, a principal component of sexual offending rehabilitation and GLM treatment, was “responsivity”. The codes were grouped into two categories: “communication skills and use of appropriate language” and “creative delivery of session material in response to learning styles”. The codes from both categories emphasised communicating and engaging with individuals creatively, based on their formulations and good lives plans. For example, using language and impromptu skills practice or “live learning” to demonstrate learning points.

### **Other**

The final theme was made of important activities that were not specific to the treatment sessions. For example, the categories were “personal awareness and self-care” and “professional development”, “supervision” and “report writing”. These categories are essential for any rehabilitation work with sexual offenders, but not specific to the GLM. This theme was excluded from Round 2 of the Delphi process as the categories were not deemed to be discreet observable characteristics.

**Figure 1**  
Themes and categories from the content analysis



### 3.4.2 Comments: Round 2

Ten participants left comments in the section at the end of the Round 2 questionnaire. All comments referenced the items as a whole as opposed to comments on specific items. Comments suggested that some of the items were generic therapist characteristics rather than GLM specific; that therapists not meeting basic standards should not facilitate on GLM-CL programmes; that items could be considered in terms of competencies that some therapists might be working towards, rather than a dichotomy of competent/non-

competent and, finally, that examples of negative practice should never be displayed by the therapist.

#### *3.4.3 Comments: Round 3*

In Round 3, comment boxes were attached to each item to elicit further suggestions from participants in relation to the revision of items. A summary of the comments for each item are shown in Table 1.



**Table 1**

Summary of participant comments on items from the Round 3 questionnaire

Item	Summary of comments
<i>"Explicitly refers to the model, when relevant, to enhance clients' understanding; for example, relating the intervention content to the consideration of clients' primary human goods"</i>	<ul style="list-style-type: none"> <li>- Concept of building a good life and the idea of working towards primary goods should be repeatedly revisited through clients' good lives plans.</li> <li>- Clients do not need to understand the model in order to take meaning and to make progress in treatment.</li> <li>- Suggestion that the "explicitly refers to the model" part of the item could be omitted.</li> </ul>
<i>"Displays appropriate use of self-disclosure and sharing of examples of primary goods to enhance understanding and illustrate how the pursuit of primary goods are universal"</i>	<ul style="list-style-type: none"> <li>- The sharing of examples of primary goods was universally seen as important; however, there were mixed opinions on whether self-disclosure was appropriate or necessary to accompany examples. For instance, some participants believed that self-disclosure should be avoided, as even seemingly innocuous self-disclosure can have negative consequences for the client and the facilitator.</li> </ul>
<i>"Appears to avoid discussions of certain issues due to lack of confidence in ability to explain or a lack of understanding of the model"</i>	<ul style="list-style-type: none"> <li>- It may be difficult to score the item objectively.</li> <li>- More clarification on what "certain issues" might be, i.e., if related to risk reduction and working towards primary human goods then the item would be an important example of negative practice.</li> <li>- Participants agreed that avoidance was problematic, but added that good role modelling, such as a therapist admitting when they do not know something, is important with regard to successful treatment outcomes.</li> </ul>
<i>"Sticks to abstract examples of fictitious case studies that seem irrelevant to the group members (e.g., in terms of ethnicity, location)"</i>	<ul style="list-style-type: none"> <li>- Case examples need to be personally relevant to the participants, considering responsivity issues.</li> <li>- The occurrence of this item may not be very common; therefore, "sticks to" could be reworded as "overuse of" or "frequent use of".</li> </ul>
<i>"Imposes one's own values or beliefs or preaches pro-social attitudes and behaviours"</i>	<ul style="list-style-type: none"> <li>- "Paternalism" or imposing own values and beliefs is not inappropriate; however, disclosing beliefs to aid understanding can be helpful and represent good modelling of pro-social attitudes.</li> <li>- "Imposes one's own values or beliefs" is important, but that the "preaches pro-social attitudes and behaviours" is too close to the example of positive practice of encouraging/modelling pro-social attitudes and behaviours.</li> <li>- "Imposes one's own values or beliefs" could be augmented to specify in what</li> </ul>

Item	Summary of comments
	manner this item would be inappropriate.
<i>“Considers clients’ individualities to encourage participation and engagement (e.g., promotes alternative modes of communication such as poetry or drawing)”</i>	<ul style="list-style-type: none"> <li>- Needs to be in accordance with the responsivity principle.</li> </ul>
<i>“Misses opportunities to link session content to the fulfilment of the clients’ good lives plans”</i>	<ul style="list-style-type: none"> <li>- Frequency of occurrence of this item is important, i.e. if it was happening on a regular basis, this would be a problem.</li> <li>- If the item was positively phrased it would more obviously be essential.</li> </ul>
<i>“Uses specific and measured praise to reinforce positive shifts/skills development (e.g., when a client identifies positive ways to achieve their good lives goals)”</i>	<ul style="list-style-type: none"> <li>- Although a basic facilitation skill, this is very important in GLM treatment.</li> </ul>
<i>“Balances the decision to either ignore or challenge inappropriate behaviour (e.g., bullying, disrespectful comments and cognitive distortions)”</i>	<ul style="list-style-type: none"> <li>- Bullying is not a good example to use, as it is something that should be challenged directly.</li> <li>- Level of challenging should be based on client-group, i.e. with client with intellectual disability who may have difficulties with self-esteem; it would be problematic to challenge every cognitive distortion.</li> </ul>
<i>“Clear and confident projection of voice that is respectful and warm in tone”</i>	<ul style="list-style-type: none"> <li>- This is an important item, but it is not specific to GLM treatment.</li> </ul>

#### *3.4.4 Results – Round 2 and Round 3*

Seventy-one items from the three rounds were endorsed by experts (rated as essential or important by >85% of the participants). The items were clustered between 12 categories that fell within one of four (the 'other' theme was excluded as it was not deemed to contain observable therapist characteristics) different themes. The items that achieved consensus are listed under one of the twelve category headings and are presented in Table 2 and displayed graphically in Figure 1. The ten items were rated as essential or important by 75–85% of participants and re-evaluated by participants in Round 3, all of which reached consensus, are also displayed in Table 2. The five items that were excluded for not meeting the consensus threshold (items that were rated as essential or important by <75% of participants) are presented in Table 3. In both Tables 2 and 3 each item is accompanied by the group percentage of agreement and an indication of what round it included/excluded.

**Table 2**

Therapist characteristics of GLM-CT included that achieved consensus

Recommended therapist characteristics items of GLM-CT	Round included	% agreement (Round 3)
<b>Practical application of the knowledge and understanding of GLM principles (GLM in Practice)</b>		
<u>Positive examples</u>		
- Demonstrates a good and current knowledge and understanding of GLM theory and philosophy	2	100%
- * Explicitly refers to the model, when relevant, to enhance clients' understanding; for example, relating the intervention content to the consideration of clients' primary human goals	3	85% (91%)
- Demonstrates that GLM can fit with other paradigms, for example, different beliefs, therapies and cultural views	2	92%
- Promotes an egalitarian view that everybody is working towards similar goals in life and that perfection is unrealistic, i.e. that the GLM is relevant to everyone	2	96%
- Displays appropriate use of self-disclosure and sharing of examples of primary goods to enhance understanding and illustrate how the pursuit of primary goods is universal	3	85% (82%)
<u>Negative examples</u>		
- * Appears to avoid discussions of certain issues due to lack of confidence in ability to explain or a lack of understanding of the model	3	81% (86%)
- Displays attitudes contrary to the ethos of the GLM (e.g., that some people cannot or will not change, that denial cannot be worked with or needs to be changed into admittance, or that facilitators are better than clients in some way)	2	100%
- Sticks to abstract examples of fictitious case studies that seem irrelevant to the group members (e.g., in terms of ethnicity, location)	3	80% (86%)
- * Imposes one's own values or beliefs or preaches pro-social attitudes and behaviours	3	80% (80%)
<b>Creative delivery of session material in response to learning styles (responsivity)</b>		
<u>Positive examples</u>		
- Adapts session material creatively (e.g., use of diagrams, pictorial aids, multimedia and role-plays) to be responsive to different learning styles while still achieving the session aims	2	100%
- Offers extra support within group or between sessions to make sure all group members understand the content	2	88%
- Considers clients' individualities to encourage participation and engagement (e.g., promotes alternative modes of communication such as poetry or drawing)	3	81% (91%)
<u>Negative examples</u>		
- Appears not to know clients' formulations and is unresponsive to different learning styles	2	100%
<b>Good Lives planning: balanced focus on avoidance and approach goals (GLM in practice)</b>		
<u>Positive examples</u>		
- Explores the clients' ideas about what a good life means to them prior to collaborating on agreed approach goals for their good lives plans. Takes disagreement into account	2	96%
- Demonstrates a good holistic understanding of clients (e.g., goals, desires, values, preferences and capabilities) when supporting them with their good lives plans.	2	100%

**Table 2**

Therapist characteristics of GLM-CT included that achieved consensus

Recommended therapist characteristics items of GLM-CT	Round included	% agreement (Round 3)
- Demonstrates a balanced focus on both approach goals and criminogenic needs while remaining realistic about what can be achieved	2	92%
- Makes positive, future-focused responses during discussions related to the future (e.g., overcoming internal and external barriers to primary human goods and the development of protective factors and positive approach goals)	2	96%
- Encourages group members to think about the function of their behaviour from the point of view of primary goods <u>Negative examples</u>	2	96%
- Demonstrates uncollaborative good lives planning (e.g., appears overly focused on file information, makes assumptions about an underlying need before discussing this with the client, or ignores the client's personal identity)	2	96%
- Demonstrates unrealistic good lives planning (e.g., GLM plans are unachievable, detached from clients' criminogenic needs, or focused on getting out of prison/hospital rather than achieving a good life)	2	96%
- Overly focuses on avoidance or reduction of risk factors without considering alternative means of managing difficult situations and enhancing well-being	2	100%
- * Misses opportunities to link session content to the fulfilment of the clients' good lives plans	3	78% (96%)
<b>Appropriate encouragement and reinforcement (therapeutic style)</b>		
<u>Positive examples</u>		
- Uses specific and measured praise to reinforce positive shifts/skills development (e.g., when a client identifies positive ways to achieve their good lives goals)	3	85% (100%)
- Reinforces positive contributions and behaviours from group members (e.g., making reflective statements, sharing difficult and shameful experiences, completion of homework / behavioural tasks and attending on time) and uses extinction with unhelpful contributions	2	92%
<u>Negative examples</u>		
- Does not address or colludes with disrespectful language or pro-offending attitudes or behaviour	2	88%
- Overly focused on negatives in clients' discourse at the expense of strengths and positives	2	92%
<b>Conducting the session (facilitation style)</b>		
<u>Positive examples</u>		
- Invites questions and reflections from group members and allows time for appropriate discussion	2	100%
- Demonstrates flexibility to shift session focus in line with the needs and suggestions of group members while maintaining integrity to the session theme, e.g., takes opportunities for learning/skills practice as they arise	2	96%
<u>Negative examples</u>		
- Fails to spot opportunities for practical learning/skills practice; only encourages skills practice when the manual instructs	2	100%
- Overly directive and inflexible: does not listen to clients' suggestions and imposes own agenda on group discussion; brings discussions to an end abruptly	2	96%
<b>Being prepared and monitoring progress (facilitation style)</b>		

**Table 2**

Therapist characteristics of GLM-CT included that achieved consensus

Recommended therapist characteristics items of GLM-CT	Round included	% agreement (Round 3)
<u>Positive examples</u>		
- Monitors learning and keeps the session focused on the achievement of aims; checks that all group members understand the topic	2	100%
- Regularly summarises learning points and makes links to previous learning	2	92%
- Remembers personal information about the clients across sessions	2	92%
<u>Negative examples</u>		
- Does not appear to be listening to clients, summarising the main learning points, noting their contributions or following through with information discussed in the session	2	88%
<b>Challenges participants in a supportive manner (therapeutic style)</b>		
<u>Positive examples</u>		
- Responds to disagreement, resistance, negative attitudes or behaviours with exploration and reflection within the group rather than closing this down	2	88%
- * Balances the decision to either ignore or challenge inappropriate behaviour (e.g., bullying, disrespectful comments and cognitive distortions)	3	85% (91%)
- Expresses confusion over any ambiguities in an enquiring rather than interrogating manner	2	96%
- Remains composed, professional and non-defensive when challenged by group members	2	100%
- Uses solution-focused and motivational techniques where appropriate	2	96%
<u>Negative examples</u>		
- Engages in confrontations with clients that excludes colleagues and other group members	2	88%
- Challenges resistance or minor things excessively during the session rather than rolling with resistance using a motivational and Socratic style	2	96%
<b>Being warm, genuine and respectful (therapeutic style)</b>		
<u>Positive examples</u>		
- Displays a genuine sense of optimism and interest in understanding each client's motives/needs in relation to helping them live a better life (not just in session delivery but during breaks and check-in)	2	100%
- Respectful of clients' goals and values: takes opportunities to be positive about clients' potential and strengths as they naturally arise	2	100%
- Shows sensitivity when group members find things difficult or upsetting and validates how they are feeling. For example, supports the use of emotional management techniques and/or allowing clients' time to compose themselves	2	100%
- Encourages group members to empathise with others in the group when appropriate	2	96%
- Displays an appropriate use of humour	2	88%
<u>Negative examples</u>		
- Appears aloof, disinterested or too serious	2	100%
- Interacts with clients in a disrespectful and blaming manner; for example, being dismissive, undermining, ridiculing, humiliating or implying that a client is wrong	2	100%
- Displays a lack of regard for clients' emotional wellbeing: does not acknowledge and/or moves on too quickly from points in the session that are difficult or emotional for group members	2	100%

**Table 2**

Therapist characteristics of GLM-CT included that achieved consensus

Recommended therapist characteristics items of GLM-CT	Round included	% agreement (Round 3)
<b>Appropriate body language and presentation (therapeutic style)</b>		
<u>Positive examples</u>		
- Displays warm and open body language (e.g., good eye contact, appropriate smiling, nodding, open posture and leaning forward)	2	100%
- Demonstrates emotional resilience: appears comfortable and confident when dealing with emotive situations in the group (e.g., uses selective empathic facial expressions and mirroring of positive emotions)	2	100%
- Appears alert and demonstrates good concentration in the session. Appropriately dressed and presented	2	92%
<u>Negative examples</u>		
- Displays inappropriate reactions to a client's disclosure that might make them feel uncomfortable (e.g., raised eyebrows, recoiling, eye-rolling and staring)	2	96%
<b>Communication skills and use of appropriate language (responsivity)</b>		
<u>Positive examples</u>		
- Uses inclusive, respectful and simple language that all group members can understand, especially with regard to GLM terms	2	100%
- Clearly and confidently communicates the aims and objectives of the session to group members	2	92%
- Clear and confident projection of voice that is respectful and warm in tone	3	85% (77%)
- Uses appropriate sexual terminology without embarrassment	2	100%
<u>Negative examples</u>		
- Uses inappropriate language (e.g., swearing, inappropriate jokes, labels, use of vulgar slang, stigmatising comments, sexist remarks or judgemental responses)	2	88%
- Sticks to a heavily worded or inflexible script that restricts group discussion	2	92%
<b>Exploration of session material (therapeutic style)</b>		
<u>Positive examples</u>		
- Guides learning and exploration through a mixture of open and Socratic questions to help clients consider different perspectives	2	96%
- Uses reflections, peer reflection and support, paraphrasing, reframing, clarifications and regular summaries between questions	2	96%
- Seeks to build on clients' existing strengths and introduce new skills in a way that enables the participants to determine whether they want to adopt these changes	2	96%
- Recognises when to allow clients space and time to consider and re-evaluate their thinking or to reflect on past experiences and process emotions safely	2	96%
<u>Negative examples</u>		
- Inappropriate questioning technique (e.g., pursues own lines of thinking and exploration, misses the chance to explore attitudes and behaviours in more depth or asks closed or leading questions)	2	88%
<b>Boundaries and co-facilitation modelling (therapeutic style)</b>		
<u>Positive examples</u>		
- Demonstrates good professional boundaries (e.g., is clear about boundaries, group rules and respects staff and client confidentiality)	2	100%
- Adequately prepared for the session (e.g., ensures good time-keeping, appropriate pre-session planning time and that handover is completed)	2	96%
- Models pro-social and respectful co-working behaviour during the	2	96%

**Table 2**

Therapist characteristics of GLM-CT included that achieved consensus

Recommended therapist characteristics items of GLM-CT	Round included	% agreement (Round 3)
session (e.g., models respectful attitudes, positive working relationships, positive gender relationships, problem-solving behaviour, collaborative decision making, turn taking and negotiation of breaks etc.)		
- Is respectful of other facilitators' views and interpretation of the GLM within the session and resolves disagreements about interpretation out of session	2	92%
- Encourages all participants to contribute to group discussion: encourages turn-taking when a group member is being dominant and supports the quieter individuals to contribute to discussions	2	96%
<u>Negative examples</u>		
- Models inappropriate and unprofessional co-facilitation behaviours (e.g., talks over co-facilitator, references gender in an inappropriate manner, contradicts co-facilitator, displays poor problem-solving skills, breaches confidentiality)	2	88%

\* = suggested revision following comments

**Table 3**

Therapist characteristics of GLM-CT excluded

Therapist characteristics agreed not to be included	Round excluded	% agreement
Over-empathises with contributions from group members	2	57%
Spends too much time exploring treatment needs when the information required has already been made available	2	69%
Overlooks inappropriate attitudes or behaviours that are counter to the ethos of the programme	2	73%
Sets achievable, behavioural goals between sessions	2	65%
Conversational style of interacting encouraging an open and transparent environment that is guided mainly by the group members	2	73%



### **3.5. Discussion**

As far as the researchers are aware, the present study represents the first Delphi method to explore which therapist skills and characteristics are important in GLM-CT. Experts generally agreed that 71 of the 76 items obtained from the content analysis in Round 1 were important. Although all ten of the items re-rated in Round 3 achieved consensus, the participant comments accompanying them provided useful information for the revision of items. To begin with, the findings suggested there was agreement that the majority of therapist characteristics previously identified by Marshall et al. (2003) were important in GLM-CT. However, the results identified some additional areas that were deemed important for therapists involved in GLM-CT. In relation to the therapist characteristics (empathy, warmth, rewarding style, level of directiveness) previously found to be related to positive change in sexual offending treatment (Marshall et al., 2002), all were recognised by experts as being important – though directiveness was represented least. This, of course, does not suggest that directiveness is not important in GLM-CT; however, it may suggest that more emphasis is placed on supporting the client to be more self-directive. Indeed, the GLM principles espouse that clients should be recognised as autonomous individuals who are supported to make their own decisions about their rehabilitation journey (Ward et al., 2006). Therefore, although directiveness has recently been mentioned as important in GLM-CT (Willis et al., 2014), the how and when of its use still needs to be elaborated upon in future guidance, especially as the specifics of directiveness in GLM-CT have been queried recently (e.g., Looman & Abracen, 2013). It may be the case that therapists are more directive at the beginning of treatment when working with clients during the GLM planning stage of treatment with a view to supporting clients to become self-directed and autonomous in

terms of their rehabilitation journey, placing therapists in a guiding rather than directive role.

Treatment guides, as opposed to rigid treatment manuals, have been recommended in GLM-CT (Willis et al., 2012), arguably requiring a greater degree of flexibility on the therapists' part with regard to session content. The results of the present study are in accord with this. For instance, a number of experts noted the importance of therapist flexibility in the session; that is, therapists being prepared to, temporarily, deviate from the session plan if relevant to clients' good lives plans. This would entail a high level of astuteness on the therapists' part to be able to decide what is relevant to the session based on their knowledge of clients' good lives plans, while in addition remaining mindful of the session aims.

Moreover, the results indicated that therapists should have a good holistic knowledge of clients in order to support them with their good lives plans. Considering the good lives plans are so central to treatment being meaningful and motivating for clients, it is not surprising that the ability to apply GLM knowledge accurately within the session was noted as important. However, in Round 3, some participants commented that while it is important that therapists be well acquainted with the model, it is not necessary for clients to know the model in order for them to understand and make progress in treatment. Given that, it follows that therapists should be creative in terms of how they make good lives plans meaningful to clients in accordance with the responsivity principle, which was emphasised by participants in the category "creative delivery of session material in response to learning styles".

It has been well recognised that a confrontational stance is not conducive to successful sexual offender treatment and is negatively related to outcomes (Fernandez &

Mann, 2010; Marshall et al., 2003b), and, additionally, this has been explicitly echoed in guidance for programmes considering adopting GLM principles (Willis et al., 2012). Therefore, it is not surprising that experts in the present study cautioned against confrontational behaviours. Instead, there was emphatic agreement that therapists in GLM-CT should be warm, genuine, respectful and supportive. It was suggested that this is demonstrated in the session by being attuned and showing sensitivity to changes in affect and being genuinely interested in helping clients build a better life. In addition, when confronted with resistance from clients, the items suggested that a non-confrontational and enquiring stance is best, with experts recommending motivational interviewing techniques such as rolling with resistance and amplifying ambivalence (Miller & Rollnick, 2012).

In relation to use of appropriate self-disclosure when sharing of examples to demonstrate the universal nature of primary goods, there were some opposing opinions presented in the Round 3 comments regarding the use of self-disclosure. Specifically, it was suggested that even innocuous self-disclosure could have potentially negative consequences. Certainly, Fernandez and Mann (2010) make a cautious distinction between modelling and self-disclosure. They emphasise that modelling should be constant in treatment, which includes expression of pro-social attitudes and behaviour, whereas self-disclosure should only be used to normalise the processes that underlie certain behaviours. However, our results did not indicate how much self-disclosure was appropriate; therefore, it seems that this is something that needs to be considered further in relation to GLM-CT.

The results displayed a noticeable emphasis on the importance of positive language and the use of future-focused reinforcing statements, especially in the categories related to “GLM planning” and “appropriate encouragement and reinforcement”. Additionally, the

celebration of clients' strengths is fundamental to the GLM-CT and, not surprisingly, this was firmly represented in the results.

### 3.5.1. *Limitations of the current study*

There are a number of limitations to this study. Firstly, a purposive sample is recommended for the Delphi method, which makes the selection of experts central to the credibility of the outcomes (Skulmoski *et al.*, 2007). While the authors feel that the eligibility criteria for both research and practice experts were sufficient and had face validity, it may be that a different panel of experts could have resulted in divergent results.

Furthermore, following suggestions from participants in Round 2, space for comments on individual items was added in Round 3, which was useful in terms of suggestions for the revision of items. However, in Round 2 there was only space for comments at the end of the questionnaire, which may have resulted in pertinent suggestions for the revision of items being missed. Conceivably, a fourth round could have been used to clarify some of the suggestions made in Round 3; however, considering the items reached the consensus level set at the beginning of the study and due to time constraints, it was decided to finish the Delphi at Round 3. In addition, a comment box could have clarified why the experts did not endorse the five excluded items (Table 3), as it was not clear why some of the items received low ratings. For instance, in regards to the item '*conversational style of interacting and encouraging an open and transparent environment that is guided mainly by the group members*', the experts may have agreed with parts of the item but not with the item as whole, and, thus, given it a low rating. Therefore, it may have been useful to have a comment box to allow experts to qualify their answers further.

Although the Delphi method is a powerful research tool for seeking consensus on topics requiring further clarification, there is a lack of agreed guidance and standards relating to interpretation and analysis of the results (Iqbal & Pison-Young, 2009). Therefore, in the present study, a content analysis was used in Round 1 to bolster the Delphi methodology. However, in order to meaningfully express each therapist characteristic as a statement in Round 2, prefixes were added to items, and, in some cases, examples from participants were used to clarify items. Although the authors endeavoured to ensure items were a credible reflection of the participants' responses, the phrasing of some items may have unintentionally distorted the meaning implied by participants in Round 1.

### *3.5.2. Implications for research and practice*

The present study was unique in that it took an important first step in terms of informing fidelity to an emerging but influential therapeutic framework. There are a number of important implications for the results of the present study. Firstly, the items could be used to form the underpinning of a therapist competency guide for GLM-CT. In addition, future research may take this understanding further to develop a fidelity framework to help with evaluation and to safeguard standards in treatment, as a GLM specific framework has not yet been established. Research might assess validity of the current items using observation of GLM-CT in practice, similar to the studies undertaken by Marshall and colleagues (Marshall et al., 2003; Marshall et al., 2002). Furthermore, once items had been refined, research could examine their relationship to treatment outcomes. In addition, the results highlighted some grey areas where more clarification is needed concerning GLM-CT: for example, use of self-disclosure and directiveness. In addition, the positive and negative

practice items could be used in supervision with therapists to help them build their therapeutic skills.

### *3.5.3. Conclusion*

In summary, the GLM represents a refreshing theoretical approach to sexual offending treatment. Its ethos, conveyed in session by its therapists, encourages a compassionate and supportive environment to engender motivation and autonomy in clients in order to shape a meaningful rehabilitation path. The present study built on previous research illuminating what therapeutic characteristics are important to enrich this therapeutic process with clients in GLM-CT specifically. In addition to therapist characteristics identified as important in previous research, the results indicated that an emphasis on future-focused and strengths-based language, motivational interviewing skills, flexibility with session material and a good knowledge of clients' good lives plans are important to consider in GLM-CT. All of these are essential to empower clients' to realise their primary goods through pro-social means. Finally, the results indicated that use of self-disclosure and directiveness might need to be clarified further in relation to GLM-CT.

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## 5. Appendices

### 5.1. Appendix A. Clinical Psychology Review style guidelines



## CLINICAL PSYCHOLOGY REVIEW

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.....  
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### Preparation of Delphi questionnaire

#### 1. Aim of study

Consider:

- Are the aims clearly described? ☐
- Does the Delphi study aim to address consensus? ☐

- ☐ Clearly reported (2)
- ☐ Partially reported (1)
- ☐ Not reported/Not applicable (0)

#### 2. How items were considered in the first questionnaire?

Were participants asked an open question, i.e. no outcomes were initially listed, or were they asked to comment on a pre-specified list? If the latter, was the source of the list identified? Where possible, the questions asked to participants should be described in the methods or made available to the reader as supplementary information.

- ☐ Clearly reported (2)
- ☐ Partially reported (1)
- ☐ Not reported/Not applicable (0)

### Delphi Participants

#### 3. The total number of participants invited |\_\_|\_\_|\_\_|

First Round |\_\_|\_\_|\_\_|

- ☐ Clearly reported (2)
- ☐ Partially reported (1)
- ☐ Not reported/Not applicable (0)

4. **What types of participants were involved in the study**, e.g., clinicians, patients, researchers or other types of participants?

Was the proportion of each type of participant described?

- ☐ Clearly reported (2)
- ☐ Partially reported (1)
- ☐ Not reported/Not applicable (0)

5. **How participants were identified/sampled**, e.g., was the expert criteria clearly defined, if applicable?

- ☐ Years of experience
- ☐ Renown
- ☐ Recommendation
- ☐ Members of an organisation
- ☐ Random
- ☐ Number of publications
- ☐ Other.....

- ☐ Clearly reported (2)
- ☐ Partially reported (1)
- ☐ Not reported/Not applicable (0)

### Methodology of the Delphi Process

#### Type of Delphi procedure

- ☐ Basic (self-administered questionnaires, sent by any means, with no meeting)
- ☐ Modified (in addition to the questionnaires, physical meeting to discuss results or to rate indicators)

6. **Administration of questionnaires:** postal, email, Internet, in person (e.g., at a clinic), or at a meeting

- ☐ Mail
- ☐ Email
- ☐ In person
- ☐ Both
- ☐ Other.....

- ☐ Clearly reported (2)
- ☐ Partially reported (1)

☐ Not reported/Not applicable (0)

**7. Information provided to participants prior to the study:** e.g., If some work had been conducted prior to the Delphi (e.g., workshop meeting, or focus groups amongst patients, literature review), were the results presented to the participants? Was the rationale for the study shared?

- ☐ Clearly reported (2)  
☐ Partially reported (1)  
☐ Not reported/Not applicable (0)

**8. Analysis of qualitative data, if applicable.**

- ☐ Clearly reported (2)  
☐ Partially reported (1)  
☐ Not reported/Not applicable (0)

**9. Rating scale reporting, if applicable.**

- Was there a rating scale?

- ☐ Yes  
☐ No

- If Yes, what were the lowest and highest possible ratings From |\_\_| to |\_\_|\_\_|  
- Was the scale clearly defined? For example, were the meanings of the lowest and highest ratings defined? ☐ Yes ☐ No

- ☐ Clearly reported (2)  
☐ Partially reported (1)  
☐ Not reported/Not applicable (0)

**10. What was asked in each round?** Where possible, the questions asked to participants should be described in the methods, or made available to the reader, as supplementary information.

- ☐ Clearly reported (2)  
☐ Partially reported (1)  
☐ Not reported/Not applicable (0)

**11. Feedback to participants after each round:** if the results were not fed back, but only certain items were carried forward to the next round (e.g., only those suggested by at least 10% were carried forward), this should be clearly described

- ☐ Clearly reported (2)
- ☐ Partially reported (1)
- ☐ Not reported/Not applicable (0)

**12. Level of anonymity should be described:** in order to be “fully anonymised”, participants should not know the identities of the other individuals in the group, nor should they know the specific answers that any other individual gave. In studies that are “quasi-anonymised”, the participants know the identities of some or all of the other individuals, but do not know how they individually responded to any of the questions in any round. In studies that are not anonymised, participants know the identity of some or all of the other individuals, and also know how some or all of them responded to any of the questions in any round.

- ☐ Clearly reported (2)
- ☐ Partially reported (1)
- ☐ Not reported/Not applicable (0)

**13. If a pre-determined definition of consensus** was used, this should be clearly described in the methods section of the study report.

- If applicable, **what threshold value was used for the Delphi method** to be stopped based on achievement of consensus?
- **Were items dropped?** What criteria were used to determine which items to drop?

- ☐ Clearly reported (2)
- ☐ Partially reported (1)
- ☐ Not reported/Not applicable (0)

## Results

**14. Number of participants invited to each round** |\_\_|\_\_|\_\_|

- ☐ Clearly reported (2)
- ☐ Partially reported (1)
- ☐ Not reported/Not applicable (0)

**15. Number who completed every round** |\_\_|\_\_|\_\_|

- ☐ Clearly reported (2)

- ☐ Partially reported (1)
- ☐ Not reported/Not applicable (0)

**16. Results for each items scored by participants in each round:** a measure of group response, preferably with a measure of distribution. If these data cannot be included in the publication, even as a supplementary file, they should be made available on request.

- Measure of group response for each item scored by participants in the final round?

- ☐ Yes
- ☐ No

- ☐ Clearly reported (2)
- ☐ Partially reported (1)
- ☐ Not reported/Not applicable (0)

**17. A comprehensive list of all the items that participants agreed should be included in the core set.**

- ☐ Clearly reported (2)
- ☐ Partially reported (1)
- ☐ Not reported/Not applicable (0)

**Additional comments:**

### 5.3. Appendix C. List of studies excluded following articles being read in full

No.	Study	Reason excluded
1	Adams, Piercy, Jurich & Lewis (1992)	The study was concerned with identifying important components of a model of adolescent AIDS/drug abuse prevention program; however, the scope of the study was broad and the program was not psychotherapeutic – that is, it was not affiliated with a core model, such as CBT.
2	Bisson et al. (2010)	The study was concerned with general psychosocial care-guidelines rather than being concerned with a core psychotherapeutic model.
3	Carrick (2004)	The study was concerned with general principles for a drug treatment programme based on a report that focused on accessible and effective drug-treatment services for young people. It was not concerned with a specific core psychotherapeutic model.
4	Doerries and Foster (2005).	The study was concerned with therapeutic characteristics for novice structural family therapists.
5	Duncan, Nicol and Ager (2004)	The study was concerned with what constitutes a good CBT treatment manual as opposed to learning more about the model.
6	Evans, Baker, Berta and Barnsley (2014)	The study focused on a model of healthcare care integration as opposed to a psychotherapeutic model.
7	Fiander and Burns (2000)	The study aimed to describe service models of community mental health practice and was not related to a core psychotherapeutic model.
8	~ Han et al. (2013)	The study was initially considered due to its abstract describing the use of the Delphi method to explore the status of CBT components for generalised-anxiety disorder (GAD); however, despite the full article being obtained through a Chinese university, an English version was unfortunately not available.
9	Jenkins and Smith (1994)	The study was concerned with the application of the Delphi method in family therapy research.
10	Johnsen (2011)	The study was concerned with exploring critical components of suicide prevention programs generally, as opposed to specific psychotherapeutic elements.
11	Kingston et al. (2009)	The aim of the study was to use to Delphi Method to create general guidelines for community members seeking to help an individual with a drinking problem.
12	Kingston et al. (2011)	The aim of the study was to use to Delphi Method to create general guidelines for community members seeking to help an individual with a substance misuse problem.
13	Langlands, Jorm, Kelly and Kitchener (2008)	The study was interested in general guidelines for depression and was not concerned with a specific psychotherapeutic model.
14	Law and Morrison (2014)	The study aimed to establish consensus about the meaning of recovery among individuals with experience of psychosis, without reference to a specific psychotherapeutic model.
15	* Levine and Fish (1999)	The aim of the study was to identify some of the ways that family therapists have remained true to structural and strategic theories. Although the study may have met the inclusion criteria, unfortunately, only the abstract was accessible.
16	McCulloch and McMurran (2007)	The study was concerning what constitutes a good CBT treatment manual in offender treatment as opposed to learning more about a specific psychotherapeutic model.
17	Norder et al. (2012)	The purpose of this study was to reach group consensus on a set of predictors of recurrent sickness absence due to depression by using a Delphi approach.
18	Primer (1996)	The study was focused on therapeutic characteristics in Family Preservation practice.
19	Thomson (1990)	The study was concerned with the use of appropriate and inappropriate uses of humour in psychotherapy generally as opposed to a specific model.
20	Tetley et al. (2012).	The model being considered in the study, The Multifactor Offender Readiness Model (MORM), was concerned with treatment readiness and engagement in offenders, as opposed to being a psychotherapeutic model.
21	Tierney and Fox (2009)	The study was concerned with general treatment of anorexia nervosa as opposed to a core psychotherapeutic model.
22	Völlm (2014)	The study was concerned with key characteristics of psychological case formulation in personality disorder offenders and was not related to a core psychotherapeutic model.
23	Williams and Haverkamp (2010)	The study was concerned with competencies considered critical for basic, independent psychotherapeutic practice with eating disordered clients, but was not concerned with a specific model.

\* Only abstract accessible

~ English version not available

#### 5.4. Appendix D. International Journal of Forensic Mental Health – Instructions for authors

##### SCHOLARONE MANUSCRIPTS™

This journal uses ScholarOne Manuscripts (previously Manuscript Central) to peer review manuscript submissions. Please read the [guide for ScholarOne authors](#) before making a submission. Complete guidelines for preparing and submitting your manuscript to this journal are provided below.

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All parts of the manuscript should be typewritten, double spaced, with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Each article should be summarized in an abstract of not more than 100 words. Avoid abbreviations, diagrams, and reference to the text in the abstract. Each author should be listed with his or her primary departmental affiliation and institution name, and city/state/country (where applicable).

**References.** References, citations, and general style of manuscripts should be prepared in accordance with the APA Publication Manual, 6th ed. Cite in the text by author and date (Smith, 1983) and include an alphabetical list at the end of the article. *Examples:*

*Journal:* Tsai, M., & Wagner, N.N. (1978). Therapy groups for women sexually molested as children. *Archives of Sexual Behaviour*, 7(6), 417-427. doi: 10.1037/0096-3445.134.2.258

*Book:* Millman, M. (1980). *Such a pretty face*. New York: W.W. Norton.

*Contribution to a Book:* Hartley, J.T., & Walsh, D.A. (1980). Contemporary issues in adult development of learning. In I.W. Poon (ed.). *Ageing in the 1980s* (pp. 239-252). Washington, DC: American Psychological Association.

**Illustrations.** Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

- 300 dpi or higher
- Sized to fit on journal page
- EPS, TIFF, or PSD format only
- Submitted as separate files, not embedded in text files

**Color Illustrations.** Color art will be reproduced in color in the online publication at no additional cost to the author. Color illustrations will also be considered for print publication; however, the author will be required to bear the full cost involved in color art reproduction. Color reprints can only be ordered if print reproduction costs are paid. Print reproduction: \$900 for the first page of color; \$450 per page for the next three pages of color. A custom quote will be provided for articles with more than four pages of color. Art not supplied at a minimum of 300 dpi will not be considered for print.

**Tables and Figures.** Tables and figures (illustrations) should not be embedded in the text, but should be included as separate sheets or files. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet.

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## 5.5. Appendix E. Initial invitation email for the Delphi method study

Dear #FirstName#,

I am a trainee clinical psychologist at the University of Edinburgh. I am inviting you to be part of an online expert panel as part of my research exploring fidelity to the principles of the Good Lives Model (GLM) in sex offender treatment programmes (SOTP). Those selected have been identified as having specific involvement in Good Lives Model (GLM) research and/or the application of the GLM principals in practice.

### Purpose of the study:

The purpose of the study is to add to the existing research on sexual offending treatment programmes by seeking expert opinion on what facilitator qualities or characteristics are important in GLM based treatment. Following this, we will construct and pilot a fidelity checklist with videotaped sessions from the Scottish GLM based programme for sexual offenders, 'Moving Forward, Making Changes' (MFMC).

### What will participation involve?

Participation will involve being part of a Delphi study comprising two initial rounds in the form of an online survey. The Delphi method aims to 'to seek expert opinion in an iterative structured manner. The key features of the method are *anonymity* between participants with *controlled feedback* provided in a structured manner' (Diamond *et al.*, 2014).

The process aims to be as straightforward as possible and should take no longer than 15–20 minutes for each round.

1. Round 1: The first round will consist of a small number of open-ended questions related to what facilitator qualities or characteristics are important in GLM treatment. After all responses have been received, the information will be collated, the key concepts will be elicited using content analysis, and the data will be used to construct the round 2 questionnaire.
2. Round 2: The second round questionnaire will display the results from round 1, followed by Likert questions based on the information provided in round 1.
3. Feedback: When all rounds of the Delphi study have been completed, detailed feedback will be provided to each participant.

	Survey open from:	Returned by:
Round 1	Open now	August 7th 2014
Round 2	August 19th 2014	September 2nd 2014

**If you would like to take part in this study or would like further information, please go to:**

#SurveyLink#

If you do not wish to respond to this survey, please click on the link below to decline:

#DeclineLink#

**I would also appreciate if you could forward the contact details of others who might meet the study criteria: having an involvement in GLM research and/or the practice of the GLM principals.**

This study has been granted ethical approval by the University of Edinburgh. If you have any concerns about this study, please contact my supervisor Dr Ethel Quayle, Senior Lecturer in Clinical Psychology, on [ethel.quayle@ed.ac.uk](mailto:ethel.quayle@ed.ac.uk)

Thanks in advance for responding to the survey,

Nick Earley  
DClinPsychol Programme  
**University of Edinburgh**

## 5.6. Appendix F. Reminder email

Dear #FirstName#,

I am a trainee clinical psychologist at the University of Edinburgh. Two weeks ago you received an email message inviting you to be part of an online expert panel as part of my research exploring fidelity to the principles of the Good Lives Model (GLM) in sex offender treatment programmes (SOTP).

I recognise that you are extremely busy and may not wish to participate; however, if you have time, I would greatly appreciate your participation. Overall, participation in the student should take no longer than 15–20 minutes.

**If you would like to take part in this study or would like further information, please go to:**

#SurveyLink#

**If you do not wish to respond to this survey, please click on the link below to decline:**

#DeclineLink#

Thanks again,

Nick Earley  
DClinPsychol Programme  
**University of Edinburgh**

## The Good Lives Model: Building Consensus about Fidelity.

**Thank you for your interest in taking part in this study. Please read the following information below before agreeing to take part.**

### **Background:**

The Good Lives Model (GLM) has created a stir in the sexual offending rehabilitation domain: it has galvanised research and generated enthusiasm in its practical application. An evidence-base for the model is growing quickly and it has been incorporated into programmes worldwide. The Scottish Government has recently sponsored the development of a GLM-based intervention programme for sexual offenders in Scotland named “Moving Forward, Making Changes (MFMC)”. As this programme is new, we are keen to think about fidelity monitoring from the beginning.

### **Purpose of the study:**

The purpose of the study is to add to the existing research on sexual offending treatment programmes by seeking expert opinion on what facilitator qualities or characteristics are important in GLM treatment. Following this, we will construct and pilot a fidelity checklist with videotaped sessions from the Scottish MFMC programme.

### **What will the study involve?**

The first part of the research is a Delphi study which aims ‘to seek expert opinion in an iterative structured manner. The key features of the method are *anonymity* between participants with *controlled feedback* provided in a structured manner’ (Diamond et al., 2014). Those invited to the panel have been identified as having an involvement in GLM research and/or the operationalisation of the GLM principles in practice.

The Delphi study comprises two initial rounds. If you decide to take part, we ask that you agree to take part in all rounds. Depending on the level of consensus achieved, a further round may be required.

1. Round 1: The first round will consist of a small number of open-ended questions related to what facilitator qualities or characteristics are important in GLM treatment. After receiving all responses, the information will be collated, the key concepts will be elicited using content analysis, and the data will be used to construct the Round 2 questionnaire.
2. Round 2: The second round questionnaire will display the results from Round 1, followed by questions based on the information provided in Round 1.
3. Potential round 3: A third round may be needed if consensus is not reached in the initial two rounds.

4. Feedback: When all rounds of the Delphi study have been completed, detailed feedback will be provided to each participant.

**The process aims to be as straightforward as possible and should take no longer than 15–25 minutes for each round.**

The timeframe for the study is below:

	Survey open from:	Returned by:
Round 1	Open now	August 8th 2014
Round 2	August 19th 2014	September 2nd 2014

#### **What else is import to consider before taking part in the study?**

- Participants' identities and responses will be made anonymous to other members of the panel.
- You can request to exit the study at any point up until all the data has been collected.
- It is hoped that the results of the study will help to further the understanding of what specific facilitator characteristics are important in GLM treatment. The result will be written up as a research paper for journal submission.
- All the anonymous data will be available by request to all participants in the study.
- This study has been granted ethical approval by the University of Edinburgh Ethics Committee.
- If you have any questions about the study you can contact the lead researcher directly by emailing Nick Earley on [n.earley@sms.ed.ac.uk](mailto:n.earley@sms.ed.ac.uk)
- If you have any concerns about the study you can contact Dr Ethel Quayle on [Ethel.Quayle@ed.ac.uk](mailto:Ethel.Quayle@ed.ac.uk)

**If you would still like to take part in the study please read the following before giving your consent:**

1. **I understand that my identity and my responses will be made anonymous to other members of the panel.**
2. **I understand that my involvement is voluntary and that I am free to exit the study and request the removal of my data at any point up during the study.**

**If you do not wish to continue with the study at this time, please exit this web page.**

**If you wish to continue, please confirm that you agree to the statements above by clicking yes and you will**

then be taken to the Round 1 questionnaire for completion.

☐ Yes

### The Good Lives Model: Building Consensus about Fidelity.

Please provide an email address, required to contact you during the next round of the study.

Email address: \*

### The Good Lives Model: Building Consensus about Fidelity.

## Section 1

The following questionnaire aims to identify:

1. What specific facilitator qualities or characteristics are important to monitor in order to safeguard fidelity or faithfulness to GLM principles?
2. How might the more general therapist characteristics shared with other treatment models be observed in GLM treatment?

---

Thinking specifically about GLM principles, what facilitator characteristics/qualities do you think are important to consider in GLM based treatment interventions?

How might the facilitator qualities you identified be recognised and/or demonstrated in a group session?

## The Good Lives Model: Building Consensus about Fidelity.

### Section 2

## Section 2

Most cognitive-behavioural therapy (CBT) group programmes have general facilitator characteristics that are thought to be important. These include communicating clearly, using the Socratic method, and displaying warmth. The following section outlines a number of qualities important in CBT-based work with offenders.

**Considering GLM treatment *specifically*, how might the descriptions below be demonstrated by facilitators during a treatment session?**

You can leave some of the boxes blank if you wish.

**Delivery is congruent with the primary values and ethos of the programme.**

What would examples of positive practice look like?

What would examples of negative practice look like?

---

**Uses open-ended and Socratic questions to explore session material and promote new thinking.**

What would examples of positive practice look like?



What would examples of negative practice look like?

---

**Interacts with participants in a warm, genuine and collaborative manner.**

What would examples of positive practice look like?

What would examples of negative practice look like?

---

**Maintains a flexible style during the session while staying focused on the session goals.**

---

**Conveys empathy during the session.**

What would examples of positive practice look like?

What would examples of negative practice look like?

**Uses motivational techniques to facilitate change.**

What would examples of positive practice look like?

What would examples of negative practice look like?

---

**Encourages a balanced contribution from participants in the group.**

What would examples of positive practice look like?

What would examples of negative practice look like?

---

**Models and encourages pro-social attitudes and behaviours that are congruent with the programme rationale.**

What would examples of positive practice look like?

What would examples of negative practice look like?

**Communicates clearly, confidently and uses appropriate language.**

What would examples of positive practice look like?

What would examples of negative practice look like?

**Displays appropriate body language during the session .**

What would examples of positive practice look like?

What would examples of negative practice look like?

**Models appropriate co-facilitator partnership.**

What would examples of positive practice look like?

What would examples of negative practice look like?

---

**Challenges participants in a supportive manner during the session.**

What would examples of positive practice look like?

What would examples of negative practice look like?

---

**Are there any further facilitator qualities/characteristics that you think are important in GLM-based treatment?**

**Finally, if relevant, how might the facilitator qualities you identified be recognised and/or demonstrated in a group session?**



## 5.8. Appendix H. Example of the coding and categorising process

The following is an example of how the coding system was executed using a response from Participant 19 to the second open-ended question in section 1: “How might the facilitator qualities/characteristics you identified be recognised and/or demonstrated in a group session?” Participant 19 gave the following response:

*“Positive attitudes towards offenders. Good skills in motivational interviewing or similar. Socratic questioning, being flexible.”*

In accordance with the aforementioned coding strategy, the above response was considered to contain four distinct units of meaning and was thus allocated four separate positive codes and assigned to four different categories and sub-categories:

1. The first meaning unit *“positive attitude towards offenders”* was assigned to the category “being warm, genuine and respectful” and to the sub-category “displays a genuine sense of optimism, motivation and encouragement”.
2. The second meaning unit was considered to be *“good skills in motivational interviewing or similar”* and was placed in the category “challenges participants in a supportive and motivational manner” and placed in the sub-category “motivational skills”.
3. The third meaning unit was considered to be *“Socratic questioning”* which was placed in the category “Exploration of session material” and was placed in the sub-category “Open-ended and Socratic questioning to consider new ways of thinking”.

4. Finally, the fourth meaning unit was considered to be "*being flexible*" and was placed in the category "conducting the session" and within the sub-category "Flexibility with session content".

## 5.9. Appendix I. Categories and themes accompanied with code quantities

Ranking	Category	Codes	+ Codes	- Codes	Theme group
1	Being warm, genuine and respectful	163	104	59	Therapeutic style
2	Exploration of session material	123	90	33	Therapeutic style
3	Conducting the session	111	63	48	Facilitation style
4	Boundaries and co-facilitation modelling	94	60	34	Facilitation style (therapeutic )
5	Appropriate use of behavioural techniques, e.g., encouragement and reinforcement	75	61	14	Therapeutic style
6	Appropriate body language and presentation	74	40	34	Facilitation style
7	Good Lives planning: balanced focus on avoidance and approach goals	61	36	25	GLM in practice
8	Challenges participants in a supportive manner	61	42	19	Therapeutic style
9	Communication skills and use of appropriate language	52	25	27	Responsivity
10	Practical knowledge and understanding of GLM principles	51	41	10	GLM in practice
11	Creative delivery of session material in response to learning styles	36	33	3	Responsivity
12	Being prepared and monitoring progress	26	22	4	Facilitation style
13	Personal awareness and self-care	17	12	5	Other
14	Professional development, supervision and report writing	10	9	1	Other



## The Good Lives Model: Building Consensus about Fidelity – Round 2

### Welcome to Round 2 of this study

Firstly, thank you for continuing to take part. The Round 2 questionnaire is based on the content analysis of the information provided in Round 1. This stage invites you to rate your agreement for each item concerning what positive and negative GLM facilitator characteristics are important to be watchful for in GLM treatment.

It is estimated that this stage should take no longer than 10–15 minutes.

Following the completion of Round 2, the results will be displayed using descriptive data analysis of the panel's responses.

If you have any questions or comments about the study please contact me directly by emailing me on [n.earley@sms.ed.ac.uk](mailto:n.earley@sms.ed.ac.uk)

If you wish to continue, please click to the next page.

Many thanks,

Nick Earley

## The Good Lives Model: Building Consensus about Fidelity – Round 2

**Please consider the importance of the following positive and negative facilitator characteristics for inclusion on a GLM fidelity checklist.**

**NB:** When rating the negative items, remember it is whether they should be included on a GLM fidelity

checklist as evidence of negative practice, rather than whether they are desirable or not.

---

## Practical application of knowledge, skills and attitudes consistent with the GLM

---

### Examples of positive practice

#### 1. Demonstrates a good and current knowledge and understanding of GLM theory and philosophy.

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

#### 2. Explicitly refers to the model, when relevant, to enhance clients' understanding; for example, relating the intervention content to the consideration of clients' primary human goals.

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

#### 3. Demonstrates that GLM can fit with other paradigms, for example, different beliefs, therapies and cultural views.

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant

☐ Should not be included

**4. Promotes an egalitarian view that everybody is working towards similar goals in life and that perfection is unrealistic, i.e. that the GLM is relevant to everyone.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**5. Displays appropriate use of self-disclosure and sharing of examples of primary goods to enhance understanding and illustrate how the pursuit of primary goods is universal.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

### Examples of negative practice

**1. Appears to avoid discussions of certain issues due to lack of confidence in ability to explain or a lack of understanding of the model.**

\*

How important is this item to look out for as an example of negative practice?

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**2. Displays attitudes contrary to the ethos of the GLM (e.g., that some people cannot or will not change, that denial cannot be worked with or needs to be changed into admittance, or that facilitators are better than clients in some way).**

\*

How important is this item to look out for as an example for negative practice?

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**3. Sticks to abstract examples of fictitious case studies that seem irrelevant to the group members (e.g., in terms of ethnicity, location).**

\*

How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**4. Imposes one's own values or beliefs or preaches pro-social attitudes and behaviours.**

\*

How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

## The Good Lives Model: Building Consensus about Fidelity – Round 2

### Creative delivery of session material in response to learning styles based on case formulations

---

#### Examples of positive practice

**1. Adapts session material creatively (e.g., use of diagrams, pictorial aids, multimedia and role-plays) to be responsive to**

**different learning styles while still achieving the session aims.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**2. Offers extra support within group or between sessions to make sure all group members understands the content.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**3. Considers clients' individualities to encourage participation and engagement (e.g., promotes alternative modes of communication such as poetry or drawing).**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

### **Examples of negative practice**

**1. Appears not to know clients' formulations and is unresponsive to different learning styles.**

\*

How important is this item to look out for as an example for negative practice?

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant

☐ Should not be included

## The Good Lives Model: Building Consensus about Fidelity – Round 2

### Good Lives planning: balanced focus on avoidance and approach goals

---

#### Examples of positive practice

**1. Explores the clients' ideas about what a good life means to them prior to collaborating on agreed approach goals for their good lives plans. Takes disagreement into account.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**2. Demonstrates a good holistic understanding of clients (e.g., goals, desires, values, preferences and capabilities) when supporting them with their good lives plans.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**3. Demonstrates a balanced focus on both approach goals and criminogenic needs while remaining realistic about what can be achieved.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important

- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**4. Makes positive, future-focused responses during discussions related to the future (e.g., overcoming internal and external barriers to primary human goods and the development of protective factors and positive approach goals).**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**5. Encourages group members to think about the function of their behaviour from the point of view of primary goods.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

### Examples of negative practice

**1. Demonstrates uncollaborative good lives planning (e.g., appears overly focused on file information, makes assumptions about an underlying need before discussing this with the client, or ignores the client's personal identity).**

\*

How important is this item to look out for as an example for negative practice?

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**2. Demonstrates unrealistic good lives planning (e.g., GLM plans are unachievable, detached from clients' criminogenic needs, or focused on getting out of prison/hospital rather than achieving a good life).**

\*  
How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

### 3. Misses opportunities to link session content to the fulfilment of the clients' good lives plans.

\*  
How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

### 4. Overly focuses on avoidance or reduction of risk factors without considering alternative means of managing difficult situations and enhancing well-being.

\*  
How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

## The Good Lives Model: Building Consensus about Fidelity – Round 2

### Appropriate reinforcement

---

Examples of positive practice



**1. Uses specific and measured praise to reinforce positive shifts/skills development (e.g., when a client identifies positive ways to achieve their good lives goals).**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**2. Reinforces positive contributions and behaviours from group members (e.g., making reflective statements, sharing difficult and shameful experiences, completion of homework / behavioural tasks and attending on time) and uses extinction with unhelpful contributions.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

### Examples of negative practice

**1. Dismisses minor changes as negligible and not worth noticing; dismisses contributions that are not in line with the session goals.**

\*

How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**2. Does not address or colludes with disrespectful language or pro-offending attitudes or behaviour.**

\*

How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends

- ☐ Unimportant
- ☐ Should not be included

### 3. Overly focused on negatives in clients' discourse at the expense of strengths and positives.

\*

How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

## The Good Lives Model: Building Consensus about Fidelity – Round 2

### Confident and encouraging facilitation style

---

#### Examples of positive practice

#### 1. Conversational style of interacting encouraging an open and transparent environment that is guided mainly by the group members.

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

#### 2. Invites questions and reflections from group members and allows time for appropriate discussion.

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends

- ☐ Unimportant  
☐ Should not be included

**3. Demonstrates flexibility to shift session focus in line with the needs and suggestions of group members while maintaining integrity to the session theme, e.g., takes opportunities for learning/skills practice as they arise.**

\*

Select at least 1 and no more than 1.

- ☐ Essential  
☐ Important  
☐ Do not know/depends  
☐ Unimportant  
☐ Should not be included

### Examples of negative practice

**1. Fails to spot opportunities for practical learning/skills practice; Only encourages skills practice when the manual instructs.**

\*

How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential  
☐ Important  
☐ Do not know/depends  
☐ Unimportant  
☐ Should not be included

**2. Overly directive and inflexible: does not listen to clients' suggestions and imposes own agenda on group discussion; brings discussions to an end abruptly.**

\*

How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential  
☐ Important  
☐ Do not know/depends  
☐ Unimportant  
☐ Should not be included

## Monitoring progress

---

### Examples of positive practice

**1. Monitors learning and keeps the session focused on the achievement of aims; checks that all group members understand the topic.**

\*

Select at least 1 and no more than 1.

☐

Essential

☐

Important

☐

Do not know/depends

☐

Unimportant

☐

Should not be included

**2. Regularly summarises learning points and makes links to previous learning.**

\*

Select at least 1 and no more than 1.

☐

Essential

☐

Important

☐

Do not know/depends

☐

Unimportant

☐

Should not be included

**3. Remembers personal information about the clients across sessions.**

\*

Select at least 1 and no more than 1.

☐

Essential

☐

Important

☐

Do not know/depends

☐

Unimportant

☐

Should not be included

**4. Agrees an agenda at the beginning of session and reviews this at the end; sets achievable, behavioural goals between sessions.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

### Examples of negative practice

**1. Does not appear to be listening to clients, summarising the main learning points, noting their contributions or following through with information discussed in the session.**

\*

How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

## The Good Lives Model: Building Consensus about Fidelity – Round 2

### Challenges participants in a supportive manner

---

#### Examples of positive practice

**1. Responds to disagreement, resistance, negative attitudes or behaviours with exploration and reflection within the group rather than closing this down.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**2. Balances the decision to either ignore or challenge inappropriate behaviour (e.g., bullying, disrespectful comments and cognitive distortions).**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**3. Expresses confusion over any ambiguities in an enquiring rather than interrogating manner.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**4. Remains composed, professional and non-defensive when challenged by group members.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**5. Uses solution-focused and motivational techniques where appropriate.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**Examples of negative practice**

**1. Overlooks inappropriate attitudes or behaviours that are counter to the ethos of the programme.**

\*

How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**2. Engages in confrontations with clients that excludes colleagues and other group members.**

\*

How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**3. Challenges resistance or minor things excessively during the session rather than rolling with resistance using a motivational and Socratic style.**

\*

How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**The Good Lives Model: Building Consensus about Fidelity – Round 2**

**Being warm, genuine, respectful and caring**

---

**Examples of positive practice**

**1. Displays a genuine sense of optimism and interest in understanding each client's motives/needs in relation to helping them live a better life (not just in session delivery but during breaks and check-in).**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**2. Respectful of clients' goals and values: takes opportunities to be positive about clients' potential and strengths as they naturally arise.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**3. Shows sensitivity when group members find things difficult or upsetting and validates how they are feeling. For example, supports the use of emotional management techniques and/or allowing clients time to compose themselves.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**4. Encourages group members to empathise with others in the group when appropriate.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included



## 5. Displays an appropriate use of humour.

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

## Examples of negative practice

### 1. Appears aloof, disinterested or too serious.

\*

How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

### 2. Interacts with clients in a disrespectful and blaming manner; for example, being dismissive, undermining, ridiculing, humiliating or implying that a client is wrong.

\*

How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

### 3. Displays a lack of regard for clients' emotional wellbeing: does not acknowledge and/or moves on too quickly from points in the session that are difficult or emotional for group members.

\*

How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends

- ☐ Unimportant
- ☐ Should not be included

#### 4. Over-empathises with contributions from group members.

\*

How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

## The Good Lives Model: Building Consensus about Fidelity – Round 2

### Body language and presentation

---

#### Examples of positive practice

#### 1. Displays warm and open body language (e.g., good eye contact, appropriate smiling, nodding, open posture and leaning forward).

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

#### 2. Demonstrates emotional resilience: appears comfortable and confident when dealing with emotive situations in the group (e.g., uses selective empathic facial expressions and mirroring of positive emotions).

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends

- ☐ Unimportant
- ☐ Should not be included

**3. Appears alert and demonstrates good concentration in the session. Appropriately dressed and presented.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**Examples of negative practice**

**1. Displays inappropriate reactions to a client's disclosure that might make them feel uncomfortable (e.g., raised eyebrows, recoiling, eye-rolling and staring).**

\*

How important is this item to look out for as an example for negative practice?

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**The Good Lives Model: Building Consensus about Fidelity – Round 2**

**Communication skills and use of appropriate language**

---

**Examples of positive practice**

**1. Uses inclusive, respectful and simple language that all group members can understand, especially with regard to GLM terms.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**2. Clearly and confidently communicates the aims and objectives of the session to group members.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**3. Clear and confident projection of voice that is respectful and warm in tone.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**4. Uses appropriate sexual terminology without embarrassment.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**Examples of negative practice**

**1. Uses inappropriate language (e.g., swearing, inappropriate jokes, labels, use of vulgar slang, stigmatising comments, sexist remarks or judgemental responses).**

\*

How important is this item to look out for as an example for negative practice?

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**2. Sticks to a heavily worded or inflexible script that restricts group discussion.**

\*

How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

## The Good Lives Model: Building Consensus about Fidelity – Round 2

### Exploration of session material techniques

---

#### Examples of positive practice

**1. Guides learning and exploration through a mixture of open and Socratic questions to help clients consider different perspectives.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**2. Uses reflections, peer reflection and support, paraphrasing, reframing, clarifications and regular summaries between questions.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**3. Seeks to build on clients' existing strengths and introduce new skills in a way that enables the participants to determine whether they want to adopt these changes.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**4. Recognises when to allow clients space and time to consider and re-evaluate their thinking or to reflect on past experiences and process emotions safely.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

### Examples of negative practice

**1. Inappropriate questioning technique (e.g., pursues own lines of thinking and exploration, misses the chance to explore attitudes and behaviours in more depth or asks closed or leading questions).**

\*

How important is this item to look out for as an example for negative practice?

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**2. Spends too much time exploring treatment needs when the information required has already been made available.**

\*

How important is this item to look out for as an example for negative practice?  
Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

## The Good Lives Model: Building Consensus about Fidelity — Round 2

### Co- facilitation modelling

---

#### Examples of positive practice

**1. Demonstrates good professional boundaries (e.g., is clear about boundaries, group rules and respects staff and client confidentiality).**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**2. Adequately prepared for the session (e.g., ensures good time-keeping, appropriate pre-session planning time and that handover is completed).**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**3. Models pro-social and respectful co-working behaviour during the session (e.g., models respectful attitudes, positive working relationships, positive gender relationships, problem-solving behaviour, collaborative decision making, turn-taking and negotiation of breaks etc.).**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**4. Is respectful of other facilitators' views and interpretation of the GLM within the session and resolves disagreements about interpretation out of session.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

**5. Encourages all participants to contribute to group discussion: encourages turn-taking when a group member is being dominant and supports the quieter individuals to contribute to discussions.**

\*

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends
- ☐ Unimportant
- ☐ Should not be included

### Examples of negative practice

**1. Models inappropriate and unprofessional co-facilitation behaviours (e.g., talks over co-facilitator, references gender in an inappropriate manner, contradicts co-facilitator, displays poor problem-solving skills, breaches confidentiality).**

\*

How important is this item to look out for as an example for negative practice?

Select at least 1 and no more than 1.

- ☐ Essential
- ☐ Important
- ☐ Do not know/depends





Unimportant



Should not be included

**Finally, do you have any comments or suggestions that you would like to make?**

## 5.11. Appendix K. Round 3 questionnaire

### Welcome to the final round of this study

Firstly, thank you for continuing to take part. Round 3 will display the overall panel consensus percentage for each of the 10 items that fell between 75% and 85%. Please use your participant number from your email to see what rating you gave each item in the previous round.

As with the previous round, Round 3 will involve re-rating the importance of the 10 examples of positive and negative facilitator characteristics for inclusion on a GLM fidelity checklist.

It is estimated that this stage should take under **5 minutes**.

Following Round 3, a full summary of the results will be displayed to each panel member.

If you have any questions or comments about the study, please contact me directly by emailing me on [n.earley@sms.ed.ac.uk](mailto:n.earley@sms.ed.ac.uk)

If you wish to continue, please click to the next page.

Many thanks,

Nick Earley

Please re-rate the importance of the following facilitator characteristics for inclusion on a GLM fidelity checklist in the light of the overall group responses below.

1. Explicitly refers to the model, when relevant, to enhance clients' understanding; for example, relating the intervention content to the consideration of clients' primary human goods.

Average percent of essential  
(5) or important (4) ratings:  
**85%**

Please see your response to this question from the previous round below (your participant number is noted in your e-mail for Round 3):

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	5	P7	4	P13	4	P19	4	P25	4
P2	4	P8	3	P14	5	P20	4	P26	5
P3	5	P9	4	P15	5	P21	5		
P4	5	P10	5	P16	4	P22	3		
P5	4	P11	2	P17	5	P23	2		
P6	5	P12	4	P18	5	P24	4		

\*

- ☐ Essential (5)
- ☐ Important (4)
- ☐ Do not know/depends (3)
- ☐ Unimportant (2)
- ☐ Should not be included (1)

Do you have any comments or suggestions for the revision of this item?

2.

Displays appropriate use of self-disclosure and sharing of examples of primary goods to enhance understanding and illustrate how the pursuit of primary goods is universal.

Average percent of essential  
(5) or important (4) ratings:

85%

Please see your response to this question from the previous round below (your participant number is noted in your e-mail for Round 3):

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	5	P7	4	P13	4	P19	4	P25	4
P2	3	P8	5	P14	3	P20	5	P26	4
P3	4	P9	4	P15	4	P21	5		
P4	4	P10	5	P16	4	P22	1		
P5	4	P11	4	P17	5	P23	4		
P6	4	P12	3	P18	4	P24	5		

\*

- ☐ Essential (5)
- ☐ Important (4)
- ☐ Do not know/depends (3)
- ☐ Unimportant (2)
- ☐ Should not be included (1)

Do you have any comments or suggestions for the revision of this item?

3.

**Appears to avoid discussions of certain issues due to lack of confidence in ability to explain or a lack of understanding of the model.**

(How important is this item to look out for as an example for negative practice?)

Average percent of essential  
(5) or important (4) ratings:  
**81%**

Please see your response to this question from the previous round below (your participant number is noted in your e-mail for Round 3):

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	5	P7	3	P13	4	P19	4	P25	4
P2	3	P8	5	P14	4	P20	3	P26	5
P3	4	P9	4	P15	4	P21	4		
P4	4	P10	5	P16	4	P22	3		
P5	4	P11	2	P17	5	P23	4		
P6	5	P12	4	P18	4	P24	5		

\*

- ☐ Essential (5)
- ☐ Important (4)
- ☐ Do not know/depends (3)
- ☐ Unimportant (2)
- ☐ Should not be included (1)

Do you have any comments or suggestions for the revision of this item?

4.

**Imposes one's own values or beliefs or preaches pro-social attitudes and behaviours.**

(How important is this item to look out for as an example for negative practice?)

Average percent of essential  
(5) or important (4) ratings:  
**81%**

Please see your response to this question from the previous round below (your participant number is noted in your e-mail for Round 3):

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	3	P7	3	P13	4	P19	3	P25	5
P2	5	P8	3	P14	5	P20	3	P26	5
P3	4	P9	5	P15	5	P21	5		
P4	5	P10	5	P16	4	P22	5		
P5	5	P11	4	P17	5	P23	5		
P6	5	P12	5	P18	5	P24	4		

\*

- ☐ Essential (5)
- ☐ Important (4)
- ☐ Do not know/depends (3)
- ☐ Unimportant (2)
- ☐ Should not be included (1)

Do you have any comments or suggestions for the revision of this item?

5.

**Sticks to abstract examples of fictitious case studies that seem irrelevant to the group members (e.g., in terms of ethnicity, location).**

(How important is this item to look out for as an example of negative practice?)

Average percent of essential  
(5) or important (4) ratings:

**81%**

Please see your response to this question from the previous round below (your participant number is noted in your e-mail for Round 3):

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	3	P7	3	P13	4	P19	4	P25	5
P2	4	P8	4	P14	5	P20	3	P26	5
P3	4	P9	4	P15	4	P21	4		
P4	4	P10	5	P16	4	P22	4		
P5	3	P11	5	P17	5	P23	4		
P6	2	P12	4	P18	4	P24	4		

\*

- ☐ Essential (5)
- ☐ Important (4)
- ☐ Do not know/depends (3)
- ☐ Unimportant (2)
- ☐ Should not be included (1)

Do you have any comments or suggestions for the revision of this item?

6.

**Considers clients' individualities to encourage participation and engagement (e.g., promotes alternative modes of communication such as poetry or drawing).**

Average percent of essential  
(5) or important (4) ratings:

**81%**

Please see your response to this question from the previous round below (your participant number is noted in your e-mail for Round 3):

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	5	P7	4	P13	5	P19	4	P25	4
P2	5	P8	5	P14	3	P20	5	P26	4
P3	5	P9	3	P15	4	P21	3		
P4	4	P10	4	P16	3	P22	5		
P5	4	P11	5	P17	5	P23	4		
P6	3	P12	4	P18	4	P24	5		

\*

- ☐ Essential (5)
- ☐ Important (4)
- ☐ Do not know/depends (3)
- ☐ Unimportant (2)
- ☐ Should not be included (1)

Do you have any comments or suggestions for the revision of this item?



7.

**Misses opportunities to link session content to the fulfilment of the clients' good lives plans.**  
(How important is this item to look out for as an example of negative practice?)

Average percent of essential  
(5) or important (4) ratings:  
**85%**

Please see your response to this question from the previous round below (your participant number is noted in your e-mail for Round 3):

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	5	P7	4	P13	4	P19	4	P25	5
P2	4	P8	3	P14	5	P20	5	P26	4
P3	5	P9	4	P15	5	P21	3		
P4	4	P10	4	P16	3	P22	4		
P5	4	P11	4	P17	4	P23	4		
P6	4	P12	4	P18	4	P24	3		

\*

- ☐ Essential (5)
- ☐ Important (4)
- ☐ Do not know/depends (3)
- ☐ Unimportant (2)
- ☐ Should not be included (1)

Do you have any comments or suggestions for the revision of this item?

8.

Uses specific and measured praise to reinforce positive shifts/skills development (e.g., when a client identifies positive ways to achieve their good lives goals).

Average percent of essential  
(5) or important (4) ratings:  
**85%**

Please see your response to this question from the previous round below (your participant number is noted in your e-mail for Round 3):

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	3	P7	4	P13	3	P19	3	P25	4
P2	4	P8	5	P14	5	P20	5	P26	5
P3	5	P9	4	P15	5	P21	5		
P4	5	P10	5	P16	4	P22	5		
P5	4	P11	5	P17	4	P23	5		
P6	4	P12	5	P18	4	P24	3		

\*

- ☐ Essential (5)
- ☐ Important (4)
- ☐ Do not know/depends (3)
- ☐ Unimportant (2)
- ☐ Should not be included (1)

Do you have any comments or suggestions for the revision of this item?

9.

Balances the decision to either ignore or challenge inappropriate behaviour (e.g., bullying, disrespectful comments and cognitive distortions).

Average percent of essential  
(5) or important (4) ratings:  
**85%**

Please see your response to this question from the previous round below (your participant number is noted in your e-mail for Round 3):

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	5	P7	4	P13	4	P19	4	P25	4
P2	4	P8	5	P14	3	P20	4	P26	4
P3	5	P9	4	P15	4	P21	3		
P4	4	P10	4	P16	4	P22	3		
P5	4	P11	5	P17	5	P23	4		
P6	3	P12	4	P18	4	P24	5		

- ☐ Essential (5)
- ☐ Important (4)
- ☐ Do not know/depends (3)
- ☐ Unimportant (2)
- ☐ Should not be included (1)

Do you have any comments or suggestions for the revision of this item?

10

**Clear and confident projection of voice that is respectful and warm in tone.**

Average percent of essential  
(5) or important (4) ratings:

**85%**

Please see your response to this question from the previous round below (your participant number is noted in your e-mail for Round 3):

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	2	P7	4	P13	2	P19	4	P25	4
P2	4	P8	5	P14	4	P20	5	P26	4
P3	5	P9	4	P15	5	P21	1		
P4	4	P10	4	P16	4	P22	4		
P5	4	P11	4	P17	5	P23	2		
P6	4	P12	4	P18	4	P24	4		

- ☐ Essential (5)
- ☐ Important (4)
- ☐ Do not know/depends (3)
- ☐ Unimportant (2)
- ☐ Should not be included (1)

Do you have any comments or suggestions for the revision of this item?

## 5.12. Appendix L. Letter of ethical approval



SCHOOL of HEALTH IN SOCIAL SCIENCE  
CLINICAL PSYCHOLOGY

The University of Edinburgh  
Medical School  
Doorway 6, Teviot Place  
Edinburgh EH8 9AG

Telephone 0131 651 3969  
Fax 0131 650 3891  
Email [submitting.ethics@ed.ac.uk](mailto:submitting.ethics@ed.ac.uk)

Nick Earley  
Trainee Clinical Psychologist

05 February 2014

Dear Nick,

### Application for Level 1 Approval

Re: The Delphi Method: A consensus approach towards identifying pertinent therapist characteristics in Good Lives Model treatment

Thank you for submitting the above research project for review by the Section of Clinical Psychology Ethics Research Panel. I can confirm that the submission has been independently reviewed and was approved on the 15<sup>th</sup> January 2014.

Should there be any change to the research protocol it is important that you alert us to this as this may necessitate further review.

Yours sincerely,

Kirsty Gardner  
Secretary  
Clinical Psychology

